CONTRACT #4
RFS # 350.50-00108
FA # 08-23921

Finance & Administration
Benefits Administration

VENDOR:
National Guardian Life Insurance Company

STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF BENEFITS ADMINISTRATION
William R. Snodgrass Tennessee Tower
312 Rosa L Parks Avenue, Suite 2600
Nashville, Tennessee 37243

Dave Goetz
COMMISSIONER

Phone: 615.741.4517
Fax: 615.253.8556

Laurie Lee
EXECUTIVE DIRECTOR

MEMORANDUM

TO: James White, Executive Director, Fiscal Review Committee

FROM: Stephanie Dickerson SD, Assistant Director of CoverKids

DATE: June 4, 2010

RE: Amendment # 1 to National Guardian Life Insurance Company (NGLIC) Contract

This is to request a start date of July 1, 2010 for the amendment to the above noted contract revising the contract to implement prospective payments as directed by Section 503 of CHIRPA (each, a "Prospective Payment") and to enhance specified dental procedures including orthodontics. This legislation ensures payments for certain healthcare services provided by Federally Qualified Health Centers (FQHCs) or Rural Health Clinics (RHCs) based upon rates established by the Comptroller of Tennessee and detailed additional dental benefits to be included for participants of CoverKids, Tennessee's SCHIP program.

While Congress passed legislation authorizing these payments last year, the Centers for Medicare and Medicaid Services (CMS) issued clarifications to the states regarding the final requirements of implementation during this calendar year. Benefits Administration worked as quickly as possible to develop this amendment upon receiving this clarification. The amendment allows CoverKids to be in compliance with the above federal legislation and ensures the continuation of the federal participation of funding for the CoverKids program at the current match level rate.

Thank you for your consideration of this request.

Supplemental Documentation Required for Fiscal Review Committee

*Contact Name:	Marlene Alvarez	*Contact Phone:	615-253-8358
*Original Contract Number:	FA-08-23921-00	*Original RFS Number:	350.50-001-08
Edison Contract Number: (*if applicable*)	2902	Edison RFS Number: (*if applicable*)	31701-50009
*Original Contract Begin Date:	March 20, 2008	*Current End Date:	December 31, 2010
Current Request Amendment Number: (*if applicable*)	1		
Proposed Amendment Effective Date: (*if applicable*)	July 1, 2010		
*Department Submitting:	Finance & Administration		
*Division:	Benefits Administration		
*Date Submitted:	June 4, 2010		
*Submitted Within Sixty (60) days:	No		
If not, explain:	As with the CoverKids amendment adding the prospective payments, this amendment was negotiated after receipt of the final federal guidelines for CHIPRA implementation.		
*Contract Vendor Name:	National Guardian Life Insurance Company		
*Current Maximum Liability:	$20,000,000.00		

*Current Contract Allocation by Fiscal Year:
(as Shown on Most Current Fully Executed Contract Summary Sheet)

FY: **2008**	FY: **2009**	FY: **2010**	FY: **2011**	FY: **2012**
$2,000,000	$7,000,000	$7,000,000	$4,000,000	

*Current Total Expenditures by Fiscal Year of Contract:
(attach backup documentation from STARS or FDAS report)

FY: **2008**	FY: **2009**	FY: **2010**	FY: **2011**	FY: **2012**
$801,926.95	$5,485,643.77	$8,181,200.78	$	

IF Contract Allocation has been greater than Contract Expenditures, please give the reasons and explain where surplus funds were spent:	**Contract expenditures are based on estimates of annual plan membership for the term of the contract. Actual membership may vary from the original estimates during the term of each contract, and therefore funding needs may vary. Surplus funds were not spent.**
IF surplus funds have been carried forward, please give the reasons and provide the authority for the carry forward provision:	**Surplus funds for the CoverKids program were carried forward to ensure adequate funding to sustain program growth. Carry forward authority is PC 1203, Section 35, item 11. A portion of surplus funds were reverted to the General Fund.**
IF Contract Expenditures exceeded Contract Allocation, please give the reasons and explain how funding was acquired to pay the overage:	**Not applicable**

Supplemental Documentation Required for Fiscal Review Committee

For all new non-competitive contracts and any contract amendment that changes Sections A or C.3. of the original or previously amended contract document, provide estimates based on information provided the Department by the vendor for determination of contract maximum liability. Add rows as necessary to provide all information requested.

If it is determined that the question is not applicable to your contract document attach detailed explanation as to why that determination was made.

*Contract Funding Source/Amount:	State:	$5,000,000	Federal:	$15,000,000
Interdepartmental:			*Other*:	
If "*other*" please define:				

Dates of All Previous Amendments or Revisions: (*if applicable*)	Brief Description of Actions in Previous Amendments or Revisions: (*if applicable*)

Method of Original Award: (*if applicable*)	RFP
*What were the projected costs of the service for the entire term of the contract prior to contract award?	$20,000,000.00

Supplemental Documentation Required for Fiscal Review Committee

For all new non-competitive contracts and any contract amendment that changes Sections A or C.3. of the original or previously amended contract document, provide estimates based on information provided the Department by the vendor for determination of contract maximum liability. Add rows as necessary to provide all information requested.

If it is determined that the question is not applicable to your contract document attach detailed explanation as to why that determination was made.

Planned expenditures by fiscal year by deliverable. Add rows as necessary to indicate all estimated contract expenditures.

Deliverable description:	FY: 2011	FY: 2012	FY:	FY:	FY:
Enhanced benefits are described within the amendment. Please refer to that document.					

Proposed savings to be realized per fiscal year by entering into this contract. If amendment to an existing contract, please indicate the proposed savings to be realized by the amendment. Add rows as necessary to define all potential savings per deliverable.

Deliverable description:	FY:	FY:	FY:	FY:	FY:

Comparison of cost per fiscal year of obtaining this service through the proposed contract or amendment vs. other options. List other options available (including other vendors), cost of other options, and source of information for comparison of other options (e.g. catalog, Web site). Add rows as necessary to indicate price differentials between contract deliverables.

Proposed Vendor Cost: (name of vendor)	FY:	FY:	FY:	FY:	FY:
Other Vendor Cost: (name of vendor)	FY:	FY:	FY:	FY:	FY:
Other Vendor Cost: (name of vendor)	FY:	FY:	FY:	FY:	FY:

National Guardian
STARS Contract # FA0823921
Edison Contract # 2902

FY	Expenditures
2008	801,926.95
STARS 2009	2,468,892.10
Edison 2009	3,016,751.67
2010	8,181,200.78
Total	14,468,771.50

NON-COMPETITIVE AMENDMENT REQUEST:

APPROVED
Commissioner of Finance & Administration

1) RFS #	31701 - 50009
2) Procuring Agency :	Finance and Administration, Benefits Administration
EXISTING CONTRACT INFORMATON	
3) Service Caption :	Provision of enhanced dental services to participants of CoverKids.
4) Contractor :	National Guardian Life Insurance Company
5) Contract #	2902 (Formerly FA-8-23921-00)
6) Contract Start Date :	March 20, 2008
7) CURRENT Contract End Date : (if ALL options to extend the contract are exercised)	December 31, 2010
8) CURRENT Maximum Cost : (if ALL options to extend the contract are exercised)	$ 20,000,000.00
PROPOSED AMENDMENT INFORMATON	
9) Amendment #	1
10) Amendment Effective Date : (attached explanation required if < 60 days after F&A receipt)	July 1, 2010
11) PROPOSED Contract End Date : (if ALL options to extend the contract are exercised)	December 31, 2011
12) PROPOSED Maximum Cost : (if ALL options to extend the contract are exercised)	$ 56,000,000.00

13) Approval Criteria : (select one)	☒	use of Non-Competitive Negotiation is in the best interest of the state
	☐	only one uniquely qualified service provider able to provide the service

14) Description of the Proposed Amendment Effects & Any Additional Service :

This amendment revises the existing contract to implement the dental enhancement as directed by Section 501 of Children's Health Insurance Program Reuthorization Act (CHIPRA). This legislation ensures enhancements to the current dental benefits which required a benefit limit increase from $600 to $1000 and requires CoverKids to provide orthodontic services.

This amendment also revises the existing contract to implement the prospective payment system ("PPS") as directed by Section 503 of CHIPRA (each, a "Prospective Payment"). This legislation ensures payments for certain dental care services provided by Federally Qualified Health Centers (FQHCs) or Rural Health Clinics (RHCs) based upon rates established by the Comptroller of Tennessee. These rates are in accordance with the rates for Medicaid reimbursable services.

The State shall be responsible for any and all remittances of Prospective Payments to a FQHC or RHC with the assistance of the Contractor. At the end of thirty (30) days following the end of each calendar quarter during the term of this Contract, commencing with the fourth quarter of calendar year 2009, the Contractor shall provide a report to the calendar quarter, for services covered under the CoverKids program for members covered by SCHIP. The State shall be responsible for identifying each FQHC and RHC and providing the Contractor with a current and up-to-date

list of FQHCs and RHCs from which to pull the report.

15) Explanation of Need for the Proposed Amendment :

This amendment is necessary in order to be in compliance with the above federal legislations that became effective in 2009 and ensures the continued federal participation of funds for the CoverKids program.

16) Name & Address of Contractor's Current Principal Owner(s) : (not required for a TN state education institution)

National Guardian Life Insurance Company
Two E. Gilman St.
Madison, WI 53703

17) Office for Information Resources Endorsement : (required for information technology service; n/a to THDA)

Documentation is ... ☒ **Not Applicable to this Request** ☐ **Attached to this Request**

18) eHealth Initiative Endorsement : (required for health-related professional, pharmaceutical, laboratory, or imaging service)

Documentation is ... ☒ **Not Applicable to this Request** ☐ **Attached to this Request**

19) Department of Human Resources Endorsement : (required for state employees training service)

Documentation is ... ☒ **Not Applicable to this Request** ☐ **Attached to this Request**

20) Description of Procuring Agency Efforts to Identify Reasonable, Competitive, Procurement Alternatives :

Benefits Administration currently provides a fully-insured benefit for participants in CoverKids, and the amendment does alter the array of benefits that the Contractor provides to enrollees in the program. National Guardian Life Insurance is positioned to provide these services to our enrollees. Further National Guardian Life Insurance is uniquely positioned to provide the necessary data regarding payment history for these select dental care services by the specified providers within their existing network.

21) Justification for the Proposed Non-Competitive Amendment :

National Guardian Life Insurance Company contracts with the providers who deliver services at the FQHCs or RHCs and maintains the data that will allow the Stare to make the prospective payments to these entities within Tennessee. They are the only vendor able to supply the required payment history data to the State.

National Guardian Life Insurance Company provides the current dental services to our enrollees and only they can increase our dental benefits, benefit limit and provide orthodontic services.

AGENCY HEAD SIGNATURE & DATE :
(must be signed & dated by the ACTUAL procuring agency head as detailed on the Signature Certification on file with OCR— signature by an authorized signatory will be accepted only in documented exigent circumstances)

SIGNATURE & DATE

CONTRACT AMENDMENT

Agency Tracking #	Edison ID	FA-08-23921-00	Amendment #
31701-50009	2902		1

Contractor	Contractor Federal Employer Identification or Social Security #
National Guardian Life Insurance Company	☐ C- or ☒ V- 39-0493780

Amendment Purpose/ Effects

Provides dental services for the CoverKids program.

Contract Begin Date	Contract End Date	Subrecipient or Vendor	CFDA #(s)
July 1, 2010	December 31, 2011	☐ Subrecipient ☒ Vendor	

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2008	$500,000.00	$1,500,000.00			$2,000,000.00
2009	$1,750,000.00	$5,250,000.00			$7,000,000.00
2010	$1,750,000.00	$5,250,000.00			$7,000,000.00
2011	$7,000,000.00	$21,000,000.00			$28,000,000.00
2012	$3,000,000.00	$9,000,000.00			$12,000,000.00
TOTAL:	$11,000,000.00	$33,000,000.00			**$56,000,000.00**

American Recovery and Reinvestment Act (ARRA) Funding – ☐ **YES** ☒ **NO**

— COMPLETE FOR AMENDMENTS —

END DATE AMENDED? ☐ YES ☐ NO

FY	Base Contract & Prior Amendments	THIS Amendment ONLY
2008	$2,000,000.00	
2009	$7,000,000.00	
2010	$7,000,000.00	
2011	$4,000,000.00	$24,000,000.00
2012		$12,000,000.00
TOTAL:	**$20,000,000.00**	**36,000,000.00**

Agency Contact & Telephone #

Marlene Alvarez, Procurement and Contracting Manager
State of Tennessee
Department of Finance and Administration/Benefits Administration
2600 WRS Tennessee Tower
312 Rosa L. Parks Avenue
Nashville, TN 37243
615-253-8358

Agency Budget Officer Approval (there is a balance in the appropriation from which this obligation is required to be paid that is not otherwise encumbered to pay obligations previously incurred)

Speed Code	Account Code
FA00001747	70804000

— OCR USE —	**Procurement Process Summary** (non-competitive, FA- or ED-type only)

AMENDMENT 1
TO CONTRACT ID NUMBER 2902 (Formerly FA-08-23921-00)

This Contract Amendment is made and entered by and between the State of Tennessee, Department of Finance and Administration, hereinafter referred to as the "State" and National Guardian Life Insurance Company, hereinafter referred to as the "Contractor." It is mutually understood and agreed by and between said, undersigned contracting parties that the subject Contract is hereby amended as follows:

1. The following provision is added as Contract Section A.9.9.:

A.9.9. Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) Prospective Payments

A.9.9.1. At the end of thirty (30) days following the end of each calendar quarter during the term of this Contract, commencing with the fourth quarter of calendar year 2009, the Contractor shall provide a report to the State to assist the State in identifying and confirming dental claims incurred at an FQHC or RHC and adjudicated within the calendar quarter, for services covered under the CoverKids program for members covered by SCHIP. The State shall be responsible for identifying each FQHC and RHC and providing the Contractor with a current and up-to-date list of FQHCs and RHCs from which to pull the report.

A.9.9.2. The State shall be responsible for determining the amount of any payment due to each FQHC or RHC pursuant to the prospective payment system ("PPS") as directed by Section 503 of CHIPRA (each, a "Prospective Payment"). The State shall be responsible for any and all remittances of Prospective Payments to an FQHC or RHC. The State and Contractor expressly acknowledge and agree that the State has sole responsibility for determining and issuing the Prospective Payment owed to the FQHC and RHC under the PPS.

A.9.9.3. The State shall be responsible for resolving any FQHC or RHC inquiries regarding Prospective Payments, including but not limited to the resolution of any adjustment inquiries and payments or payments returned to the State after remittance to the FQHC or RHC. The State shall have sole responsibility for resolving any overpayment or underpayment of the Prospective Payment to any FQHC or RHC as well as the recovery of any potential third party liability that may or may not be available to offset against the amount of the Prospective Payment. In addition, the State shall be responsible for providing FQHCs and RHCs any notice, report or other form or filing required by federal or state law for tax, regulatory or other purposes, including without limitation the provision of Form 1099s, related to the Prospective Payment.

A.9.9.4. The State may request, and upon request the Contractor shall provide, assistance with claims incurred at a FQHC or RHC to resolve any Prospective Payment inquiries, at the time the inquiry is presented to the State. The State shall not wait until the end of the quarter to reconcile or the end of the year to resolve FQHC and RHC inquiries.

A.9.9.5. For purposes of Contract Section 9.9.9., the parties expressly acknowledge and agree that the Contractor is acting at the State's direction to provide a quarterly report to the State for the sole purposes of facilitating Prospective Payments to FQHCs and RHCs. Contractor is not acting as an insurer under the laws of the State of Tennessee. The State is solely responsible for determining the accuracy and appropriateness of any Prospective Payment made to a FQHC or RHC.

A.9.9.6. Any obligations imposed on the Contractor for purposes of Contract Section 9.9.9 shall not survive beyond the termination of this Agreement and all such obligations hereunder shall be deemed complete and fulfilled upon the termination of this Agreement.

2. The text of Contract Section A.4. Benefits is deleted in its entirety and replaced with the following:

A.4. Benefits

The Contractor shall be responsible for ensuring that the following benefits are provided for Enrollees under Age 19 enrolled in CoverKids. Pursuant to Contract Sections A.4.1. and A.4.2., the State hereby approves the addition of dental benefits, including orthodontics benefits, to the Plan, as more fully set forth in the Member Handbook, which details additional dental benefits that shall be effective as of July 1, 2010.

The Contractor shall be responsible for ensuring children enrolled in CoverKids prior to July 1, 2010 must wait 12 months before they can obtain orthodontic benefits. All members enrolled in CoverKids with an effective date after July 1, 2010 must wait twelve (12) months from their effective date to obtain orthodontics benefits.

The Contractor shall allow each child enrolled in CoverKids prior to July 1, 2010 $400 additional dental benefits up to a $1000 benefit limit for calendar year 2010.

DENTAL BENEFITS	GROUP ONE CHILD	GROUP TWO CHILD	AMERICAN INDIAN/ ALASKAN NATIVE (AI/AN)
Preventive -- Fluoride treatments (1 year of age and older) or fluoride varnish not to exceed twice a calendar year up to age 14 -- Dental sealants for permanent molars, no limit -- 2 cleanings per calendar year	No copayment	No copayment	No copayment
Diagnostic Services -- 2 oral exams per calendar year	No copayment	No copayment	No copayment
Emergency Services -- 2 visits per calendar year during office hours -- 2 visits per calendar year after office hours	$15 copayment	$5 copayment	No copayment
Restorative Services -- Stainless steel crowns -- Routine fillings (silver or tooth colored)	$15 copayment	$5 copayment	No copayment
Extractions	$15 copayment	$5 copayment	No copayment
Radiographs -- Bitewing x-rays no more frequently than once per calendar year (2 years of age and older) -- Full mouth x-rays no more frequently than once every three calendar years	No copayment	No copayment	No copayment
Therapeutic Pulpotomy	$15 copayment	$5 copayment	No copayment
Anesthesia	$15 copayment	$5 copayment	No copayment
Other Dental Services	$15 copayment	$5 copayment	No copayment
Orthodontics Services (as of July 1, 2010) • 12-month waiting period*	$15 copayment	$5 copayment	No copayment
Deductibles	None	None	None
Annual Benefit Maximum per child	$1000	$1000	$1000
Lifetime Orthodontics Maximum amount person**	$1250	$1250	$1250
Annual Out of Pocket Maximum as a Percentage (%) of Family Income per calendar year	5%	5%	Not applicable

* Children enrolled in CoverKids prior to July 1, 2010 must wait 12 months before they can obtain orthodontic benefits. Children enrolled in CoverKids on or after July 1, 2010 must wait 12 months before they can obtain orthodontic benefits.

** The Lifetime Orthodontics Maximum limit is not applicable to the family's five percent (5%) cost sharing.

Note: The copayments indicated are the maximum amounts allowable per visit. No more than one copayment can be charged for a single visit.

The benefit shall not exceed $1000 per child per calendar year. For the purpose of the annual maximum, the time period will be the twelve months of the calendar year initiated by the child's original effective date of coverage (beginning of a month). Each child will receive $400 additional benefits in calendar year 2010 and it will begin no later than July 1, 2010 and extend to December 31, 2010. Notwithstanding the benefit cap of $1000 per child, the Contractor shall, at a minimum, provide to each child the services required by the basic dental package detailed below.

DENTAL SERVICE CATEGORY **Provided during a calendar year without consideration of the benefit cap of $1000**		
Type of Dental Service	**Frequency during a calendar year**	**Service by Dental Code**
Preventive	No less than one service	D1120
Diagnostic Services	No less than one service	D0120 D0150
Emergency Services	No less than two services	D9110 D9440
Restorative Services	No less than two services	D2140 D2150 D2160 D2330 D2331
Extractions	No less than two services	D7140 D7210 D7250
Radiographs	No less than one service	D0210 D0220 D0230 D0270 D0272
Anesthesia	Whenever medically indicated	D9230 D9248
Orthodontics	12 month waiting period	Note – DentaQuest to insert these D CPT codes for orthodontic benefits.

A.4.1. The Contractor shall maintain a year to date calculation of all copayments required by Enrollees. The Contractor shall also maintain, in its enrollment database, an indicator which identifies Enrollees that are subject to the application of the five percent (5%) out of pocket cap during any specific calendar year. This five (5) percent out of pocket maximum is accumulated across all benefits (medical, vision, and dental).The out of pocket limit does not apply to individuals from families with incomes in excess of Two Hundred Fifty Percent (250%) of the FPL or American Indian or Alaskan Natives.

A.4.2. In instances where an Enrollee is no longer required to pay a copayment for a service (the Enrollee has met the five percent (5%) out of pocket cap through medical, dental or a combination of these) the Contractor shall pay the provider the full allowable amount. In these cases, the Contractor shall apply the allowable amount less the applicable copayment to the $1,000 payment cap.

3. The text of Contract Section B.1. is deleted in its entirety and replaced with the following:

B.1. This Contract shall be effective for the period commencing on March 20, 2008, 2010, and ending on December 31, 2011. The State shall have no obligation for services rendered by the Contractor which are not performed within the specified period.

4. The text of Contract Section C.1. is deleted in its entirety and replaced with the following:

C.1. Maximum Liability. In no event shall the maximum liability of the State under this Contract exceed Fifty-Six Million Dollars ($56,000,000.00). The payment rates in Section C.3 shall constitute the entire compensation due the Contractor for the Service and all of the Contractor's obligations hereunder regardless of the difficulty, materials or equipment required. The payment rates include, but are not limited to, all applicable taxes, fees, overheads, and all other direct and indirect costs incurred or to be incurred by the Contractor.

The Contractor is not entitled to be paid the maximum liability for any period under the Contract or any extensions of the Contract for work not requested by the State. The maximum liability represents available funds for payment to the Contractor and does not guarantee payment of any such funds to the Contractor under this Contract unless the State requests work and the Contractor performs said work. In which case, the Contractor shall be paid in accordance with the payment rates detailed in Section C.3. The State is under no obligation to request work from the Contractor in any specific dollar amounts or to request any work at all from the Contractor during any period of this Contract.

5. The text of Contract Section C.3. is deleted in its entirety and replaced with the following:

C.3. Payment Methodology. The Contractor shall be compensated based on the payment rates herein for units of service authorized by the State in a total amount not to exceed the Contract Maximum Liability established in Section C.1.

a. The Contractor's compensation shall be contingent upon the satisfactory completion of units, milestones, or increments of service defined in Section A.

b. The Contractor shall be compensated based upon the following payment rates:

(1) For service performed from July 1, 2010 through December 31, 2011, the following rates shall apply, based upon the number of Enrollees certified by the Eligibility Determination Contractor to the Contractor;

	Distribution of Premium to Administration and Benefits Component	Premium Rates In effect from June 1, 2008- Dec. 31, 2008	Premium Rates In effect from Jan. 1, 2009- Dec. 31, 2009	Premium Rates In effect from Jan. 1, 2010- June 30, 2010	Premium Rates In effect from July 1, 2010- Dec. 31, 2010	Premium Rates In effect from Jan. 1, 2011- June 30, 2011	Premium Rates In effect from July. 1, 2011 – Dec. 31, 2011	Premium Rates In effect from Jan. 1, 2012 – Dec. 31, 2012
Group One Child (monthly) [1]	Amount of Premium	$17.17	$18.51	$19.77	$22.12	$22.12	$26.73	$26.73
	Amount of Premium for Administration	$1.62	$1.71	$1.80	$1.80	$1.80	$1.80	$1.80
Group Two Child (monthly) [2]	Amount of Premium	$14.20	$15.16	$16.05	$19.02	$19.02	$24.36	$24.36
	Amount of Premium for Administration	$1.47	$1.54	$1.62	$1.62	$1.62	$1.62	$1.62
AI/AN Child (monthly)[3]	Amount of Premium	$15.18	$16.21	$17.31	$20.95	$20.95	$26.25	$26.25
	Amount of Premium for Administration	$1.52	$1.60	$1.68	$1.68	$1.68	$1.68	$1.68

[1] Group One Child is defined as a covered child who is in a family with an income at or above 150 percent of FPL.

[2] Group Two Child is defined as a covered child who is in a family with an income below 150 percent of FPL and therefore subject to reduced copayments.

[3] AI/AN Child is defined as a covered child who is (a) certified American Indian/Alaskan Native (AI/AN) and (b) a member of a family with an income less than or equal to 250 percent of the FPL, as reported by the Eligibility Determination Contractor to the Contractor for the coverage period.

c. In the event that the coverage of an Enrollee is terminated on a retroactive basis, the State shall reimburse any claims payments made by the Contractor for services rendered during the period of the retroactive cancellation.

(1) If this Contract is extended pursuant to Section B.2., the following shall apply. For service performed from January 1, 2011, through December 31, 2011 the Contractor shall be compensated based upon the payment rates in Section C.3.b. (1) above but adjusted by the percentage increase, if any, between the Consumer Price Index for All Urban Consumers (CPI-U): U.S. city average, Dental Services, not seasonally adjusted, index base period: 1982-84=100), published by the United States Department of Labor, Bureau of Labor Statistics (or its successor index) in August, 2010 and that figure published in the same month, 12-months prior.

(2) If this Contract is extended pursuant to Section B.2., the following shall apply. For service performed from January 1, 2012, through December 31, 2012, the Contractor shall be compensated based upon the payment rates in Section C.3.b. (1) above but adjusted by the percentage increase, if any, between the Consumer Price Index for All Urban Consumers (CPI-U): U.S. city average, Dental Services, not seasonally adjusted, index base period: 1982-84=100), published by the United States Department of Labor, Bureau of Labor Statistics (or its successor index) in August, 2011 and that figure published in the same month, 12-months prior.

(3) For the purpose of the payment amounts detailed in this Section, the premium for children and for low income children will be payable on a monthly basis for each month of coverage (a month is defined as the first day of a month to the last day of the month).

6. The text of Contract Section E.2. is deleted in its entirety and replaced with the following:

E.2. Communications and Contacts. All instructions, notices, consents, demands, or other communications required or contemplated by this Contract shall be in writing and shall be made by certified, first class mail, return receipt requested and postage prepaid, by overnight courier service with an asset tracking system, or by EMAIL or facsimile transmission with recipient confirmation. Any such communications, regardless of method of transmission, shall be addressed to the respective party at the appropriate mailing address, facsimile number, or EMAIL address as set forth below or to that of such other party or address, as may be hereafter specified by written notice.

The State:

Ms. Marlene D. Alvarez, Manager of Procurements and Contracts
Department of Finance and Administration, Benefits Administration
312 Rosa L. Parks Avenue,
2600 WRS Tennessee Tower
Nashville, TN 37243-1102
Phone: 615.253.8358
Fax: 615.253.8556
Email Address: Marlene.Alvarez@state.tn.us

The Contractor:

David Allen, FSA, MAAA, Assistant Vice President and Actuary
National Guardian Life Insurance Company
Two E. Gilman St.
Madison, WI 53703

Telephone Number: 608-443-5277
Fax Number: 608-257-1808
Email Address: djallen@nglic.com

All instructions, notices, consents, demands, or other communications shall be considered effectively given upon receipt or recipient confirmation as may be required.

7. The following provision is added as Contract Section E.8.:

E.8. Voluntary Buyout Program. The Contractor acknowledges and understands that, for a period of two years beginning August 16, 2008, restrictions are imposed on former state employees who received a State of Tennessee Voluntary Buyout Program (VBP) severance payment with regard to contracts with state agencies that participated in the VBP.

a. The State will not contract with either a former state employee who received a VBP severance payment or an entity in which a former state employee who received a VBP severance payment or the spouse of such an individual holds a controlling financial interest.

b. The State may contract with an entity with which a former state employee who received a VBP severance payment is an employee or an independent contractor. Notwithstanding the foregoing, the Contractor understands and agrees that there may be unique business circumstances under which a return to work by a former state employee who received a VBP severance payment as an employee or an independent contractor of a State contractor would not be appropriate, and in such cases the State may refuse Contractor personnel. Inasmuch, it shall be the responsibility of the State to review Contractor personnel to identify any such issues.

c. With reference to either subsection a. or b. above, a contractor may submit a written request for a waiver of the VBP restrictions regarding a former state employee and a contract with a state agency that participated in the VBP. Any such request must be submitted to the State in the form of the *VBP Contracting Restriction Waiver Request* format available from the State and the Internet at: www.state.tn.us/finance/rds/ocr/waiver.html. The determination on such a request shall be at the sole discretion of the head of the state agency that is a Party to this Contract, the Commissioner of Finance and Administration, and the Commissioner of Human Resources.

8. Contract Attachment 3 is deleted in its entirety and replaced with the new Contract Attachment 3 attached hereto.

9. Contract Attachment 7 attached hereto is added as a new Contract Attachment.

The revisions set forth herein shall be effective as of July 1, 2010. All other terms and conditions not expressly amended herein shall remain in full force and effect.

IN WITNESS WHEREOF,

NATIONAL GUARDIAN LIFE INSURANCE COMPANY:

CONTRACTOR SIGNATURE **DATE**

PRINTED NAME AND TITLE OF CONTRACTOR SIGNATORY (above)

DEPARTMENT OF FINANCE AND ADMINISTRATION:

M. D. GOETZ, JR., COMMISSIONER DATE

Contract Attachment 3
Quarterly Management Reporting Requirements

As required by Contract Section A.10., the Contractor shall submit Management Reports by which the State can assess the CoverKids Dental program costs and usage, as well as results in meeting the Performance Guarantee requirements as contained in Contract Attachment 2. Reports shall be submitted in hard copy medium. Management Reports shall include:

1) **Performance Guarantee Tracking**, as detailed at Contract Attachment 2 (each component to be submitted at the frequency indicated), shall include:

   - Status report narrative
   - Detail report on each performance measure by appropriate time period

- **CoverKids Dental Benefit Savings and Payments,** must be submitted as follows distinguishing between in-network and out-of-network:

GROUP ONE CHILD

Type of Service	Number of Services	Submitted Charge	Allowed Amount	Network Savings	Patient Payment	Plan Benefit
Preventive						
Diagnostic						
Emergency						
Restorative						
Simple Extractions						
Radiographs						
Therapeutic Pulpotomy						
Orthodontic						
Total						

GROUP TWO CHILD

Type of Service	Number of Services	Submitted Charge	Allowed Amount	Network Savings	Patient Payment	Plan Benefit
Preventive						
Diagnostic						
Emergency						
Restorative						
Simple Extractions						
Radiographs						
Therapeutic Pulpotomy						
Orthodontic						
Total						

AMERICAN INDIAN/ ALASKAN NATIVE CHILD

Type of Service	Number of Services	Submitted Charge	Allowed Amount	Network Savings	Patient Payment	Plan Benefit
Preventive						
Diagnostic						
Emergency						
Restorative						
Simple Extractions						
Radiographs						
Therapeutic Pulpotomy						
Orthodontic						
Total						

3) **Network and Out-of-Network by:**
   - Submitted charges
   - Benefits Paid
   - Member Utilization

4) **Summary Plan Information:**

Premium Category	Subscribers	Premium	Total Claims
Group One Child			
Group Two Child			
American Indian/ Alaskan Native Child			
Total			

5) **Quarterly Network Changes Update Report, displaying the following:**
   - Present Network of Participating Providers by Specialty
   - Additions to the Network by Name, Specialty and Location
   - Terminations to the Network by Name, Specialty and Location
   - Targeted areas for recruitment

CoverKids Enhanced Dental Benefits

Benefit Limits:
Calendar Year Maximum - $1000
Lifetime Orthodontics Maximum - $1250

Public Sector Procedure Code	Description
140	EMERGENCY ORAL EXAM (AFTER REGULAR HOURS)
160	DETAILED AND EXTENSIVE ORAL EVALUATION - PROBLEM-FOCUSED
170	RE-EVALUATION - LIMITED, PROBLEM FOCUSED
180	COMPREHENSIVE PERIODONTAL EVALUATION - NEW OR ESTABLISHED PATIENT
240	OCCLUSAL-SINGLE FILM
277	VERTICAL BITEWINGS- 7 TO 8 FILMS
321	TEMPOROMANDIBULAR JOINT - FILMS (SERIES)
340	CEPHALOMETRIC FILM
350	ORAL/FACIAL IMAGES (INCLUDES INTRA AND EXTRAORAL IMAGES)
360	CONE BEAM CT-CRANIOFACIAL DATA CAPTURE
363	CONE BEAM-THREE DIMENSIONAL IMAGE RECONSTRUCTION USING EXISTING DATA
415	COLLECTION OF MICROORGANISMS FOR CULTURE AND SENSITIVITY
431	ADJUNCTIVE DIAGNOSTIC TEST THAT AIDS IN DETECTION OF MUCOSAL ABNORMALITIES
460	PULP VITALITY TEST
470	DIAGNOSTIC CASTS
1205	TOPICAL APPLICATION OF FLUORIDE- INCLUDING PROPHYLAXIS- ADULT
1206	TOPICAL FLUORIDE VARNISH;THERAPEUTIC APPLICATION FOR MODERATE TO HIGH RISKPATI
1330	ORAL HYGIENE INSTRUCTION
2390	RESIN BASED COMPOSITE CROWN - ANTERIOR
2543	ONLAY-METALLIC-THREE SURFACES
2544	ONLAY-METALLIC-FOUR OR MORE SURFACES
2644	ONLAY- PORCELAIN/CERAMIC-FOUR OR MORE SURFACE
2782	CROWN - 3/4 CAST NOBLE METAL
2783	CROWN - 3/4 PORCELAIN/CERAMIC

2790	HIGH NOBLE METAL, FULL CAST
2791	BASE METAL, FULL CAST
2792	NOBLE METAL, FULL CAST
2799	PROVISIONAL CROWN
2910	RECEMENT INLAY
2960	LAMINATE VENEER-PREFORMED
2962	VENEER, PORCELAIN (LABORATORY)
2971	ADDITIONAL PROCEDURES TO CONSTRUCT NEW CROWN UNDER EXISTING PARTIAL
2980	CROWN REPAIR
2999	UNSPECIFIED RESTORATIVE PROCEDURE
3110	PULP CAP-DIRECT (EXCLUDING FINAL RESTORATION)
3120	PULP CAP, INDIRECT (EXCLUDING FINAL RESTORATION)
3331	TREATMENT OF ROOT CANAL OBSTRUCTION; NON-SURGICAL ACCESS
3332	INCOMPLETE ENDODONTIC THERAPY; INOPERABLE OR FRACTURED TOOTH
3346	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - ANTERIOR
3347	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - BICUSPID
3348	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - MOLAR
3410	APICOECTOMY - SEPARATE SURGICAL PROCEDURE
3421	APICOECTOMY / PERIRADICULAR SURGERY - BICUSPID (FIRST ROOT)
3425	APICOECTOMY / PERIRADICULAR SURGERY - MOLAR (FIRST ROOT)
3430	RETROGRADE FILLING (PER ROOT)
4249	CROWN LENGTHENING, HARD AND SOFT TISSUE
4260	OSSEOUS SURGERY (INCLUDING FLAPENTRY & CLOSURE)4 OR MORE CONTIGUOUS TEETH
4261	OSSEOUS SURGERY (INCLUDING FLAP ENTRY AND CLOSURE), 1 TO 3 TEETH PER QUAD
4263	BONE REPLACEMENT GRAFT - FIRST SITE IN QUADRANT
4265	BIOLOGIC MATERIAL TO AID IN SOFT AND OSSEOUS TISSUE REGENERATION
4266	GUIDED TISSUE REGENERATION - RESORBABLE BARRIER,PER SITE,PER TOOTH
4271	FREE SOFT TISSUE GRAFT
4273	SUBEPITHELIAL CONNECTIVE TISSUE GRAFT
4321	PROVISIONAL SPLINTING - EXTRACORONAL
4342	PERIODONTAL SCALING & ROOT PLANNING, 1 TO 3 TEETH, PER QUADRANT

4355	FULL MOUTH DEBRIDEMENT TO ENABLE COMPREHENSIVE PERIODONTAL EVALUATION.
4381	LOCALIZED DELIVERY OF CHEMOTHERAPEUTIC AGENTS
4910	PERIODONTAL MAINTENANCE FOLLOWING ACTIVE THERAPY
4999	UNSPECIFIED PERIODONTAL PROCEDURE
5130	IMMEDIATE UPPER DENTURE
5140	IMMEDIATE LOWER DENTURE
5225	MAXILLARY PARTIAL DENTURE-FLEXIBLE BASE INCLUDING CLASPS,RESTS & TEETH
5226	MANDIBULAR PARTIAL DENTURE-FLEXIBLE BASE (INCLUDING CLASPS,RESTS & TEETH)
5281	REMOVABLE UNILATERAL PARTIAL DENTURE ONE PIECE CASTING-CHROME
5820	UPPER DENTURE - TEMPORARY (PARTIAL STAYPLATE)
5821	LOWER DENTURE - TEMPORARY (PARTIAL STAYPLATE)
5850	TISSUE CONDITIONING - UPPER
5862	PRECISION ATTACHMENT
6010	SURGICAL PLACEMENT OF IMPLANT BODY: ENDOSTEAL IMPLANT
6056	PREFABRICATED ABUTMENT
6057	CUSTOM ABUTMENT
6059	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (HIGH NOBLE METAL)
6065	IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN
6066	IMPLANT SUPPORTED PORCELAIN FUSED TO METAL CROWN (TITANIUM, TITANIUM ALLOY....
6069	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD(HIGH NOBLE METAL)
6240	PORCELAIN FUSED TO HIGH NOBLE METAL
6241	PORCELAIN FUSED TO BASE METAL
6242	PORCELAIN FUSED TO NOBLE METAL
6545	RETAINER-CAST METAL FOR RESIN BONDED FIXED PROSTHESIS
6740	CROWN - PORCELAIN/CERAMIC
6750	PORCELAIN FUSED TO HIGH NOBLE METAL
6751	PORCELAIN FUSED TO BASE METAL
6752	PORCELAIN FUSED TO NOBLE METAL
6930	RECEMENT BRIDGE
6950	PRECISION ATTACHMENT
6972	PREFABRICATED POST AND CORE (IN ADDITION TO BRIDGE RETAINER)

6973	CORE BUILD UP FOR RETAINER, INCLUDING ANY PINS
7111	CORONAL REMNANTS - DECIDUOUS TOOTH
7241	REMOVAL OF IMPACTED TOOTH - COMPLETELY BONY, WITH UNUSUAL COMPLICATIONS
7311	ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS;1 TO 3 TEETH PER QUADRANT
7410	EXCISION OF BENIGN LESION UP TO 1.25 CM
7880	OCCLUSAL ORTHOTIC DEVICE
7953	BONE REPLACEMENT GRAFY FOR RIDGE PRESERVATION; PER SITE
8020	LIMITED ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION
8050	INTERCEPTIVE ORTHODONTIC TREATMENT OF THE PRIMARY DENTITION
8060	INTERCEPTIVE ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION
8070	COMPREHENSIVE ORTHODONTIC TREATMENT - TRANSITIONAL DENTITION
8080	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION
8090	COMPREHENSIVE ORTHODONTIC TREATMENT - ADULT DENTITION
8210	REMOVABLE APPLIANCE THERAPY - MINOR HABIT CONTROL
8220	FIXED APPLIANCE THERAPY - MINOR HABIT CONTROL
8660	PRE-ORTHODONTIC TREATMENT VISIT
8670	PERIODIC ORTHODONTIC TREATMENT VISIT (AS PART OF CONTRACT)
8680	ORTHODONTIC RETENTION
8690	ORTHODONTIC TREATMENT (ALTERNATIVE BILLING TO CONTROL FEE)
8692	REPLACEMENT OF LOST OR BROKEN RETAINER
8999	UNSPECIFIED ORTHODONTIC PROCEDURE
9120	FIXED PARTIAL DENTURE SECTIONING
9210	LOCAL ANESTHESIA NOT IN CONJUNCTION WITH OPERATIVE OR SURGICAL PROCEDURES
9215	LOCAL ANESTHETIC
9420	HOSPITAL VISIT
9430	OFFICE VISIT, REGULAR HOURS
9610	THERAPEUTIC DRUG INJECTION
9630	OTHER DRUGS/MEDICAMENTS
9910	APPLICATION OF DESENSITIZING MEDICAMENTS.
9911	APPLICATION OF DESENSITIZING RESIN FOR CERVICAL AND/OR ROOT SURFACE, PER TOOTH
9930	COMPLICATIONS (POSTSURGICAL) UNUSUAL CIRCUMSTANCES

9940	OCCLUSAL GUARD
9951	OCCLUSAL ADJUSMENT, LIMITED
9971	ODONTOPLASTY 1 - 2 TEETH; INCLUDES REMOVAL OF ENAMEL PROJECTIONS
9972	EXTERNAL BLEACHING - PER ARCH
9999	UNSPECIFIED (TO BE DESCRIBED BY ATTENDING DDS)

CONTRACT SUMMARY SHEET

12-11-07

RFS #	Contract #
350.50 — 001 — 08	FA-08-23921-00 Edison # 2902
State Agency	**State Agency Division**
Finance and Administration	Benefits Administration
Contractor Name	**Contractor ID # (FEIN or SSN)**
National Guardian Life Insurance Company	☐ C- or ☒ V- 39-0493780

Service Description

Provides dental services for the CoverKids program.

Contract Begin Date	Contract End Date	SUBRECIPIENT or VENDOR?	CFDA #
March 20, 2008	December 31, 2010	Vendor	

Mark Each TRUE Statement

☒ Contractor is on STARS

☒ Contractor's Form W-9 is on file in Accounts

Allotment Code	Cost Center	Object Code	Fund	Funding Grant Code	Funding Subgrant Code
350.50	300	084	11		

FY	State	Federal	Interdepartmental	Other	TOTAL Contract Amount
2008	$500,000.00	$1,500,000.00			$2,000,000.00
2009	$1,750,000.00	$5,250,000.00			$7,000,000.00
2010	$1,750,000.00	$5,250,000.00			$7,000,000.00
2011	$1,000,000.00	$3,000,000.00			$4,000,000.00
TOTAL:	$5,000,000.00	$15,000,000.00			$20,000,000.00

OCR RELEASED
APR 10 2008
TO ACCOUNTS

— COMPLETE FOR AMENDMENTS ONLY —

FY	Base Contract & Prior Amendments	THIS Amendment ONLY
TOTAL:		
End Date:		

State Agency Fiscal Contact & Telephone #

Maureen Abbey
20th Floor, Tennessee Tower
615-741-6070

State Agency Budget Officer Approval

Maureen Abbey

Funding Certification (certification required by T.C.A. § 9-4-5118, that there is a balance in the appropriation from which the obligated expenditure is required to be paid that is not otherwise encumbered to pay obligations previously incurred)

Contractor Ownership (complete for ALL base contracts — N/A to amendments or delegated authorities)

☐ African American ☐ Person w/ Disability ☐ Hispanic ☐ Small Business ☐ Government
☐ Asian ☐ Female ☐ Native American ☒ NOT Minority/Disadvantaged

Contractor Selection Method (complete for ALL base contracts — N/A to amendments or delegated authorities)

☒ RFP ☐ Competitive Negotiation * ☐ Alternative Competitive Method *
☐ Non-Competitive Negotiation * ☐ Negotiation w/ Government (ID, GG, GU)

*** Procurement Process Summary** (complete for selection by Non-Competitive Negotiation, Competitive Negotiation, OR Alternative Method)

OIR/fcm
3/14/08

CONTRACT
BETWEEN THE STATE OF TENNESSEE,
DEPARTMENT OF FINANCE AND ADMINISTRATION
AND
NATIONAL GUARDIAN LIFE INSURANCE COMPANY

This Contract, by and between the State of Tennessee, Department of Finance and Administration, hereinafter referred to as the "State" and National Guardian Life Insurance Company, hereinafter referred to as the "Contractor," is for the provision of fully insured dental coverage for eligible individuals participating in CoverKids, Tennessee's State Children's Health Insurance Plan, as further defined in the "SCOPE OF SERVICES."

The Contractor is For Profit Corporation.
Contractor Federal Employer Identification or Social Security Number: 39-0493780
Contractor Place of Incorporation or Organization: Wisconsin

A. SCOPE OF SERVICES:

A.1. The Contractor shall provide all service and deliverables as required, described, and detailed by this Scope of Services and shall meet all service and delivery timelines specified in the Scope of Services section or elsewhere in this Contract.

A.2. POTENTIAL ENROLLEES

The Contractor agrees to provide fully insured dental plan coverage, based upon the benefits provided for in this Contract to Enrollees of CoverKids but excluding individuals enrolled in HealthyTNBabies. Enrollees include children under age 19 enrolled in CoverKids medical coverage, hereafter to be collectively referred to as CoverKids. Those Enrollees who are participating in HealthyTNBabies due to their pregnancy are not eligible for dental benefits. The Contractor shall comply with all applicable administrative rules and CoverKids written policies and procedures, as may be amended from time to time. CoverKids shall provide Contractor with copies of such rules and policies. Contractor shall adhere to its standard administrative policies and procedures, including without limitation dental policies, claims administration procedures, provider reimbursement practices and grievance procedures, in administering its fully insured coverage. The State shall be the Contract holder, and the persons covered through the CoverKids program shall be Enrollees, who receive descriptions of the coverage in a Member Handbook (MH). When used in this Contract, the term "Member" shall have the same meaning as the term "Enrollee."

Enrollees are defined as:

Group One Child: Enrollees who are a member of a family with an income between 150 percent and 250 percent of the Federal Poverty Level (FPL) as reported by the State's Eligibility Determination Contractor to the Contractor for the coverage period. Also included in this group are children from families with incomes greater than 250% of FPL and who pay monthly premiums. Full premiums must be paid for each child in a family in this category on a monthly basis. Premiums from the State or from the Enrollee will be paid to the Dental Benefits Contractor.

Group Two Child: Enrollees who is a member of a family with an income below 150 percent of FPL as reported by the State's Eligibility Determination Contractor to the Contractor for the coverage period.

American Indian and Alaskan Native Child (AI/AN): American Indian and Alaska Native individuals (individually or collectively, "AI/AN"), as defined by the Indian Health Care Improvement Act of 1976 and certified by the State's Eligibility Determination Contractor, will be exempt from all cost sharing to the extent that such children are covered by State Children's Health Insurance Plan (SCHIP) as required by Federal law. This group includes Enrollees who are (a) certified AI/AN, and (b) members of families with incomes less than or equal to 250 percent of the FPL, as reported by the State's Eligibility Determination Contractor to the Contractor for the coverage period.

A.3. PROVIDER NETWORK

A.3.1 The Contractor shall maintain and administer a Plan dental provider network covering the entire State of Tennessee service area, for Enrollees, in accordance with this Contract with coverage effective June 1, 2008. The Contractor further agrees to maintain under contract, participation by General and Pediatric Dentists and Dental Specialists (i.e. Oral Surgeons, Endodontists, Periodontist and Pedodontists) as needed and necessary to continuously provide high quality, cost effective services. Each Enrollee shall be required to obtain covered services from any general or pediatric dentist in the Contractor's network accepting new patients. The Contractor shall maintain a network of dental providers with a sufficient number of providers who accept CoverKids Enrollees within each geographical location in the state so that appointment waiting times do not exceed three (3) weeks for regular appointments and forty-eight (48) hours for urgent care. The Contractor must consider the following:

A.3.1.1 The anticipated CoverKids enrollment;

A.3.1.2 The expected utilization of services, taking into consideration the characteristics and health care needs of the CoverKids population;

A.3.1.3 The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted CoverKids services;

A.3.1.4 The number of network providers who are not accepting CoverKids Enrollees;

A.3.1.5 The geographic location of providers and CoverKids Enrollees, considering distance, travel time, and whether the location provides physical access for CoverKids Enrollees with disabilities and

A.3.1.6 The Contractor must participate in the State's efforts to promote the delivery of services in a culturally competent manner to all Enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

A.3.2 The Contractor shall prepare each February a GeoAccess analysis of provider accessibility using the same standards that are detailed in Contract Attachment 2, Performance Guarantee #7. The State shall then review the network accessibility analysis and shall inform the Contractor, in writing, of any deficiencies it identifies which deny reasonable access to dental care. The Contractor shall respond to the State, within ten (10) business days and in writing, as to the action it intends to take to correct said deficiencies.

A.3.2.1. If the Contractor revises the provider reimbursement methodology or payment amounts, the State may require the Contractor to execute a GeoAccess analysis of provider accessibility using the same standards detailed in Contract Attachment 2, Performance Guarantee # 7. The State shall then review the network accessibility analysis and shall inform the Contractor, in writing, of any deficiencies it identifies which deny reasonable access to dental care. The Contractor shall respond to the State, within ten (10) business days and in writing, as to the action it intends to take to correct said deficiencies.

A.3.2.2. The Contractor shall maintain the capability to respond to inquiries from Enrollees concerning participation by dentists in the network, by specialty by county. Such capabilities shall be by toll-free telephone and web based provider search capability. The Contractor shall provide toll-free telephone line accessible to Enrollees that provides information to Enrollees about how to access needed services.

A.3.2.3. The Contractor shall contract only with dentists who are duly licensed to provide such dental services. In addition, the Contractor shall require that all providers maintain all licenses and accreditations in existence at the time of selection as a network provider and in order to continue their status as a network provider. The Contractor shall perform on a continuous basis appropriate provider credentialing that assures the quality of network providers. Re-credentialing of network providers must be performed at least every three (3) years. The Contractor is responsible for assuring that all persons, whether they are employees, agents, subcontractors, providers or anyone acting for or on behalf of the Contractor, are legally authorized to render service under applicable state law and/or regulations. Failure to adhere to this provision shall result in assessment of $250 per calendar day for each day that personnel are not licensed as required by applicable state law and/or regulation.

A.3.2.4. The Contractor shall maintain communication with providers to ensure a high degree of continuity in the provider base and ensure that the providers are familiar with the CoverKids benefits and procedural requirements. There must be provisions for face-to-face contact in addition to telephone and written contact for the purpose of monitoring through statistical analysis, surveys and other techniques, provider conformance with plan standards and quality requirements.

A.3.2.5. The Contractor shall notify all network providers of and enforce compliance with all provisions relating to utilization management procedures. The Contractor shall require all network providers to file claims, associated with their services, directly with the Contractor on behalf of Enrollees. Claims payment dispute or request for authorization shall not cause a denial, delay, reduction, termination or suspension of any appropriate services to an eligible CoverKids member ages 0 through 18 years of age. In the event there is a claim for emergency dental services, the party receiving a request for authorization to treat any member shall insure that the member is treated immediately and payment for the claim must be approved or disapproved based on the definition of emergency dental services. Prior authorization shall not be required for emergency services.

A.3.2.6. The Contractor shall cooperate fully with audits the State may conduct of management to include clinical processes and outcomes, internal audits, provider networks, and any other aspect of the program the State deems appropriate (at the State's expense). The State may select any qualified persons, or organization to conduct the audits. To the extent allowed by applicable law, the State agrees that persons or organizations conducting audits of the Contractor shall be prohibited from disclosing confidential patient records or proprietary or confidential information reasonably designated as such by the Contractor.

A.3.2.7. The Contractor shall maintain an internal quality assurance plan. The Contractor shall provide the State with a summary of the plan indicating areas addressed, established criteria and standards and those methods employed to evaluate results.

A.3.2.8. If the Contractor's network is unable to provide necessary, dental services covered under the contract to a particular Enrollee, the Contractor must adequately and timely cover these services out of network for the Enrollee, for as long as the Contractor is unable to provide them.

A.4. BENEFITS

The Contractor will be responsible for ensuring that the following benefits are provided for Enrollees under Age 19 enrolled in CoverKids. The required benefits by dental CDT codes are listed in Contract Attachment 5.

CoverKids Dental Service Category

DENTAL BENEFITS	GROUP ONE CHILD	GROUP TWO CHILD	AMERICAN INDIAN/ ALASKAN NATIVE (AI/AN) CHILD
Preventive -- Fluoride treatments (1 year of age and older) or fluoride varnish not to exceed twice a calendar year up to age 14 -- Dental sealants for permanent molars, no limit -- 2 cleanings per calendar year	No copayment	No copayment	No copayment
Diagnostic Services -- 2 oral exams per calendar year	No copayment	No copayment	No copayment
Emergency Services -- 2 visits per calendar year during office hours -- 2 visits per calendar year after office hours	$15 copayment	$5 copayment	No copayment
Restorative Services -- Stainless steel crowns -- Routine fillings (silver or tooth colored)	$15 copayment	$5 copayment	No copayment

Extractions	$15 copayment	$5 copayment	No copayment
Radiographs -- Bitewing x-rays no more frequently than once per calendar year (2 years of age and older -- Full mouth x-rays no more frequently than once every three calendar years	No copayment	No copayment	No copayment
Therapeutic Pulpotomy	$15 copayment	$5 copayment	No copayment
Anesthesia	$15 copayment	$5 copayment	No copayment
Other Dental Services	$15 copayment	$5 copayment	No copayment
Deductibles	None	None	None
Annual Benefit Maximum per child	$600	$600	$600
Annual Out of Pocket Maximum as a Percentage (%) of Family Income per calendar year	5%	5%	Not applicable

Note: The copayments indicated are the maximum amounts allowable per visit. No more than one copayment can be charged for a single visit.

The benefit shall not exceed $600 per child per calendar year. For the purpose of the annual maximum, the time period will be the twelve months of the calendar year initiated by the child's original effective date of coverage (beginning of a month). Calendar year 2008 will begin no later than June 1, 2008 and extend to December 31, 2008. Notwithstanding the benefit cap of $600 per child, the Contractor shall, at a minimum, provide to each child the services required by the basic dental package detailed below.

DENTAL SERVICE CATEGORY **Provided during a calendar year without consideration of the benefit cap of $600**		
Type of Dental Service	**Frequency during a calendar year**	**Service by Dental Code**
Preventive	No less than one service	D1120
Diagnostic Services	No less than one service	D0120 D0150
Emergency Services	No less than two services	D9110 D9440
Restorative Services	No less than two services	D2140 D2150 D2160 D2330 D2331
Extractions	No less than two services	D7140 D7210 D7250
Radiographs	No less than one service	D0210 D0220 D0230 D0270 D0272
Anesthesia	Whenever medically indicated	D9230 D9248

A.4.1 The Contractor shall maintain a year to date calculation of all copayments required by Enrollees. The Contractor shall also maintain, in its enrollment database, an indicator which identifies Enrollees that are subject to the application of the five percent (5%) out of pocket cap during any specific calendar year. This five (5) percent out of pocket maximum is accumulated across all benefits (medical, vision, and dental).The out of pocket limit does not apply to individuals from families with incomes in excess of 250% of the FPL or American Indian or Alaskan Natives.

A.4.2 In instances where an Enrollee is no longer required to pay a copayment for a service (the Enrollee has met the 5% out of pocket cap through medical, dental or a combination of these) the Contractor shall pay the provider the full allowable amount. In these cases, the Contractor shall apply the allowable amount less the applicable copayment to the $600 payment cap.

A.5. Cost Sharing

A.5.1 The Contractor shall report cost sharing requirements, based upon claims filed by providers, to the Medical Plan Administrator on a daily basis. The information, which shall include patient name, date of service and patient copayment/coinsurance, shall be transmitted to the Medical Plan Administrator in an encrypted, secure electronic file. The Medical Plan Administrator shall report to the Contractor on a daily basis the information on Enrollees who have met or exceeded the five percent (5%) out of pocket maximum. The Medical Plan Administrator and the Contractor are expected to enter into a business trading agreement, as required by the Health Insurance Portability and Accountability Act.

A.5.2 When advised by the Medical Plan Administrator that the plan Enrollee has reached or exceeded the out of pocket maximum, the Contractor shall provide information through written correspondence to the plan Enrollee advising them that for the balance of the plan year that they will no longer be required to pay copayments/coinsurance for covered dental expenses. The Contractor shall not have responsibility for the reimbursement to the family when the 5% out of pocket maximum has been met. In situations where the family has exceeded the 5% out of pocket maximum, the reimbursement to the family will be the responsibility of the Medical Plan Administrator.

A.5.3 The Contractor shall maintain a process, through a service center, that would enable providers to verify that the plan Enrollee has reached or exceeded their annual out of pocket maximum.

A.5.4 Network providers or collection agencies acting on the provider's behalf may not bill Enrollees for amounts other than applicable cost sharing responsibilities for CoverKids. Providers may seek payment from an Enrollee in the following situation:

A.5.4.1 If the service(s) is not covered by CoverKids, the provider shall inform the Enrollee the service(s) is not covered prior to providing the service. The provider is required to inform the Enrollee of the non-covered service and have the Enrollee acknowledge the information. If the Enrollee still requests the service, the provider shall obtain such acknowledgment in writing prior to rendering the service. The provider may bill the Enrollee the total amount specified in the provider participation agreement. Non-covered services will not apply to any service or benefit maximum accumulators.

A.6. PREMIUM BILLING AND COLLECTION

A.6.1 The Contractor shall collect the appropriate premium amounts from Enrollees over 250% of the Federal Poverty Level. (Enrollees under 250% are not required to remit premiums).

A.6.2 The Contractor shall maintain accurate records of earned and unearned premiums received and premium refunds.

A.6.3 The Contractor shall send billing statements to Enrollees at their home address and collect all premium payments (whether monthly or benefit period) in a time and manner consistent with its standard administrative procedures.

A.6.4 The Contractor shall implement a notification process concerning premiums due on a monthly basis and a process to suspend and subsequently terminate coverage for individuals who fail to pay premiums in a timely fashion. The process shall assure that:

A.6.4.1 Premium billings are consistently generated on a date agreed upon with the State,

A.6.4.2 Premiums are due from members by the 1st day of each month of Enrollee coverage, unless mutually agreed upon by the Contractor and the State,

A.6.4.3 Dental benefit payments are suspended when an Enrollee fails to pay premiums by the due date designated,

A.6.4.4 The Contractor notifies the State's Eligibility Determination Contractor when families paying premiums have been terminated for nonpayment of premiums,

A.6.4.5 Enrollees who do not remit premium payment in accordance with payment policies are promptly terminated effective to the last date for which premiums were paid and

A.6.4.6 There is a reinstatement policy in place for Enrollees who were terminated from CoverKids coverage due to failure to pay premiums on a timely basis. Once an Enrollee is disenrolled from CoverKids for failure to pay required premiums, applicants will not be eligible for CoverKids coverage until payment for unpaid amounts is made and for six (6) months after the disenrollment for nonpayment of premiums.

A.7. CLAIMS PROCESSING

A.7.1 The Contractor shall process all dental claims in strict accordance with the CoverKids Member Handbook, and its clarifications and revisions. The Contractor may not modify these benefits during the term of this Contract without the approval of the State.

A.7.1.1 Upon agreement of the State and the Contractor, the Contractor shall modify its benefits administration system to reflect approved Plan benefit amendments (new, changed, or cancelled) within 30 days of the parties mutual agreement of the amendments. Should said benefit amendment(s) not be effective within 30 days, the Contractor shall have until the effective date of the amendment to modify its benefits administration system.

A.7.2 The Contractor shall ensure that the majority of all claims will be paperless for the Enrollees. Providers will have the responsibility through their contract with the Contractor to submit claims directly to the Contractor.

A.7.3 The Contractor shall ensure the electronic data processing (EDP) environment (hardware and software), data security, and internal controls meet all present standards, and will meet all future standards, required by the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191. Said standards shall include the requirements specified under each of the following HIPAA subsections:

- Electronic Transactions and Code Sets
- Privacy
- Security
- National Provider Identifier
- National Employer Identifier
- National Individual Identifier
- Claims attachments
- National Health Plan Identifier
- Enforcement

The Contractor shall maintain an EDP and electronic data interface (EDI) environment that meets the requirements of this Contract and meets the privacy and security requirements of HIPAA. The Contractor must maintain its disaster recovery plan for restoring the application software and current master files and for hardware backup if the production systems are destroyed.

A.7.4 To maintain the privacy of personal health information, the Contractor agrees to accept and use a method of secure email for daily communications between the Contractor and both the State and the State's Eligibility Determination Contractor.

A.7.5 The Contractor shall confirm eligibility of each Enrollee as claims are submitted, on the basis of the enrollment information provided by the State's Eligibility Determination Contractor, which applies to the period during which the charges were incurred. The Contractor shall process said claims, in an accurate manner, either filed directly by Enrollees and/or the provider(s).

A.7.6 The State shall establish all Plan benefits, and have the authority to approve the Member Handbooks. Said approval shall not unreasonably be withheld.

A.7.6.1 The State shall have responsibility for and authority to clarify and/or revise the benefits available through CoverKids, but these must be agreed to by Contractor, since the coverage is fully insured coverage.

A.7.6.2 The Contractor shall, when processing/adjudicating claims, employ its medical necessity guidelines to the extent that those guidelines do not conflict with or limit the provisions as outlined in the CoverKids Member Handbook.

A.7.7 To ensure the efficient and timely processing of claims and the adequate capture of data, the Contractor shall provide Enrollees with identification cards. Identification cards shall contain unique identifiers for each Enrollee; such identifier shall NOT be the member's Federal Social Security Number. The cost of these items shall be borne by the Contractor. The State reserves the authority to review any claim forms and identification cards prior to issuance for use. Contractor shall update enrollment and shall mail Enrollee I.D. cards no later than 14 calendar days from receipt of the new enrollment or change in enrollment data.

A.7.8 The State shall assist Contractor in identifying fraud and performing fraud investigations of Enrollees and providers for the purpose of recovery of overpayments due to fraud. In the event the Contractor discovers evidence that an unusual transaction has occurred that merits further investigation, the Contractor shall inform Benefits Administration. Additionally, the Contractor will assist the State in identifying fraud and performing fraud investigations with Enrollees and providers.

A.8 CUSTOMER AND ADMINISTRATIVE SERVICES

A.8.1 The Contractor shall maintain a full service staff to respond to inquiries, correspondence, complaints and problems. The Contractor shall answer, in writing, within ten (10) business days ninety percent (90%) of all written inquiries from Enrollees concerning requested information, including the status of claims submitted and benefits available through the CoverKids plan, its clarifications and revisions.

A.8.2 The State shall consult with Contractor on proposed revisions to the CoverKids benefits. When so requested, the Contractor shall provide information regarding:

- Industry practices; and
- The overall cost impact to the program; and
- Any cost impact to the Contractor's fee; and
- Impact upon utilization management performance standards; and
- Necessary changes in the Contractor's reporting requirements; and
- System changes.

A.8.3 The Contractor shall maintain a formal grievance procedure, by which Enrollees and providers may appeal: decisions regarding benefits administration; medical necessity determinations; and disputes arising from the utilization management program. At Contract implementation, the Contractor shall provide to the State two (2) written copies describing in detail the Contractor's grievance procedures. The State reserves the right to review the procedure and make recommendations, where appropriate.

A.8.4 The State appeals process is available to Enrollees after the Contractor's appeal process has been exhausted. The Contractor shall have the appropriate qualified professionals available to participate in the State appeal process and to be available to personally attend the State appeals meetings when requested by the State. The Contractor shall have a qualified individual available to provide support to the State Appeals Coordinator in the research and development of appeals.

A.8.4.1 Should the State override the Contractor's decision in an appeal, and mandate benefits that are not covered in the Member Handbook (MH), the State shall directly fund the costs of those benefits and reimburse the Contractor for the costs.

A.8.5 The Contractor shall respond to all inquiries in writing from the Benefits Administration within one (1) week after receipt of said inquiry. In cases where additional information to answer the State's inquiry is required, the Contractor shall notify the State immediately as to when the response can be furnished to the State.

A.8.6 The Contractor shall maintain statewide, toll-free phone lines manned by qualified benefit specialists and for the exclusive purpose of handling inquiries from Enrollees.

A.8.7 The Contractor shall designate an individual with overall responsibility for administration of this Contract.

A.8.8 The parties shall meet periodically, but no less than quarterly, to discuss any problems and/or progress on matters outlined by either party.

A.8.8.1 The Contractor shall have in attendance, the representatives from its organizational units required to respond to topics indicated by the State's agenda. The Contractor shall provide advice, assistance and information to the State regarding applicable existing and proposed Federal and State laws and regulations affecting managed care entities.

A.8.8.2 The State shall have in attendance, when requested by the Contractor, the representatives from its organizational units required to respond to topics indicated by the State's agenda.

A.8.9 The Contractor shall, in consultation with and following approval by the State, print and distribute all Member Handbooks, identification cards, provider directories, letters, administrative forms and manuals pertaining to or sent to Enrollees. Additionally, the Contractor must develop and print Member Handbooks detailing the benefits, procedures for accessing services, and other information helpful to Enrollees.

A.8.10 If the Contractor maintains State-dedicated Internet pages, it shall provide up to date information concerning plan benefits and the provider networks. The Contractor shall provide advice and assistance with regard to questions regarding effective dates, benefit levels, premiums and cessation of coverage as requested by the State, Enrollees, and providers.

A.8.11 The Contractor shall perform, following review and approval by the State, customer satisfaction surveys. The survey shall be conducted no more frequently than once during each calendar year at a time mutually agreed upon by the State and the Contractor but no later than the month of October. The survey shall involve a statistically valid random sample of parents and/or guardians of Enrollees. The State reserves the right to review and mandate changes in the survey it feels are necessary to obtain valid, reliable, unbiased results. Those changes may include, but are not limited to, changes in the research design, units of analysis or observation, study dimension, sample size, sample frame, sample method, coding, or evaluation method. Based upon the results of the survey, the Contractor and the State shall jointly develop an action plan to correct problems or deficiencies identified through this activity.

A.8.12 The Contractor shall conduct a provider satisfaction survey of the participating network dentists and dental specialist, following approval by the State of the form, content and proposed administration of the survey, each October or November and report the results to the State by January 30 of the following year.

A.8.13 The Contractor shall meet and confer at least twice each calendar year with representatives of a dental services provider organization designated by the State to discuss plan operations and network participation issues. The State shall be provided an opportunity to attend and observe the Contractor's sessions.

A.9 DATA AND SPECIFIC REPORTING REQUIREMENTS

The Contractor shall:

A.9.1 Maintain a secure electronic data interface with the CoverKids State's Eligibility Determination Contractor for the purpose of accessing enrollment information. The Contractor is responsible for equipping itself

with the hardware and software necessary for achieving and maintaining access. The Contractor shall engage in a monthly reconciliation process with the CoverKids State's Eligibility Determination Contractor to ensure enrollment files are up to date and accurate.

A.9.8.1 Notwithstanding the requirement to maintain enrollment data, the Contractor is not authorized to initiate data changes to the system without the State's approval. This prohibition shall include, but not necessarily be limited to: initiation, termination, and/or changes of coverage.

A.9.2 Maintain, in its computer system, in-force enrollment records of all Enrollees.

A.9.3 Maintain a duplicate set of all records relating to the benefit payments in electronic medium, usable by the State and Contractor for the purpose of disaster recovery. Such duplicate records are to be stored at a secure fire, flood, and theft- protected facility located away from the storage location of the originals. The duplicate data processing records shall be updated, at a minimum, on a daily basis and retained for a period of 60 days from the date of creation. Upon notice of termination or cancellation of this Contract, the original and the duplicate data processing records medium, and the information they contain shall be conveyed to the State on or before the effective date of termination or cancellation.

A.9.4 Reconcile, within ten (10) working days of receipt, payment information provided by the State. Upon identification of any discrepancies, the Contractor shall immediately advise the State.

A.9.5 Annually provide the State with a GeoNetworks® report showing service and geographic access (see Contract Attachment 2: Performance Guarantee # 7). The State shall review the network structure and shall inform the Contractor in writing of any deficiencies the State considers to deny reasonable access to health care. The State and Contractor shall then mutually develop a plan of action to correct said deficiencies within sixty (60) days.

A.9.6 The Contractor is required to transmit plan enrollment data monthly and dental claims quarterly to the State's healthcare decision support system (DSS) vendor (currently Thomson Healthcare, Medstat) until all claims incurred during the term of this Contract have been paid. Data shall be submitted in the format detailed in Contract Attachment 4. The Contractor shall ensure that all claims processed for payment have valid provider identifications and complete ADA codes (and when applicable, updated versions).

For each quarter of the Contract term, and any extensions thereof, claims data must meet the quality standards detailed in Contract Attachment 2: Performance Guarantee # 9, as determined by the State's healthcare claims data management vendor (currently Thomson Healthcare, Medstat).

The Contractor will work with the State's DSS vendor to identify a mutually-agreeable data format similar to the format detailed in Attachment 4 for these transmissions, and is responsible for the cost incurred by the DSS vendor to develop, test and implement conversion programs for the Contractor's claims data. The State's DSS vendor currently charges a maximum of $30,000 per new contractor. Furthermore, the Contractor will pay during the full term of this Contract all applicable fees as assessed by the State's DSS vendor related to any data format changes, which are Contractor-initiated or are due to meeting compliance with new regulations. The Contractor will also pay all applicable fees related to any DSS vendor efforts to correct Contractor data quality errors that occur during the term of this Contract.

Claims data are to be submitted to the State's data management vendor no later than the last day of the month following the end of each calendar quarter.

A.9.7 Maintain an electronic interface with the Medical Plan Administrator for the purpose of reconciling and aggregating family out of pocket costs. The Contractor's computer system shall be compatible or have the capability to utilize the enrollment information provided by the State's Eligibility Determination Contractor in the format of HIPAA 834 or 837 or other mutually agreed upon format by the State's Eligibility Determination Contractor and the Medical Plan Administrator.

A.9.8 The Contractor is responsible for equipping itself with the hardware and software necessary for achieving and maintaining access.

A.10 SUBMIT MANAGEMENT REPORTS

The Contractor shall submit Management Reports in a mutually agreeable electronic format (MSWord, MSExcel, etc.), of the type, at the frequency, and containing the detail described in Contract Attachment 3. Reporting shall continue for the twelve (12) month period following termination of the Contract.

The Contractor shall also generate and submit to the State, within five working days of the end of each Contract quarter, a Quarterly Network Changes Report (see Contract Attachment 3, # 5), also in electronic format.

A.11 READINESS REVIEW

The Contractor shall cooperate with the State, or with an entity designated by the State, in the completion of a readiness review with the initiation of the coverage and services identified in this Contract.

A.12 SERVICES PROVIDED BY THE STATE

A.12.1 The State shall provide enrollment records through the State's Eligibility Determination Contractor. These records shall include changes in the status of Enrollees.

A.12.2 The State may conduct, or designate an entity to conduct on its behalf, a readiness review prior to or coincidental with the effective date of coverage and the services identified in this Contract.

B. CONTRACT TERM:

B.1. This Contract shall be effective for the period commencing on March 20, 2008, and ending on December 31, 2010. The State shall have no obligation for services rendered by the Contractor which are not performed within the specified period.

B.2. Term Extension. The State reserves the right to extend this Contract for an additional period or periods of time representing increments of no more than one year and a total contract term of no more than five (5) years, provided that such an extension of the contract term is effected prior to the current, contract expiration date by means of an amendment to the Contract. If the extension of the Contract necessitates additional funding beyond that which was included in the original Contract, the increase in the State's maximum liability will also be effected through an amendment to the Contract, and shall be based upon payment rates provided for in the original Contract.

C. PAYMENT TERMS AND CONDITIONS:

C.1. Maximum Liability. In no event shall the maximum liability of the State under this Contract exceed Twenty Million Dollars and No Cents ($20,000,000.00). The payment rates in Section C.3 shall constitute the entire compensation due the Contractor for the Service and all of the Contractor's obligations hereunder regardless of the difficulty, materials or equipment required. The payment rates include, but are not limited to, all applicable taxes, fees, overheads, and all other direct and indirect costs incurred or to be incurred by the Contractor.

The Contractor is not entitled to be paid the maximum liability for any period under the Contract or any extensions of the Contract for work not requested by the State. The maximum liability represents available funds for payment to the Contractor and does not guarantee payment of any such funds to the Contractor under this Contract unless the State requests work and the Contractor performs said work. In which case, the Contractor shall be paid in accordance with the payment rates detailed in Section C.3. The State is under no obligation to request work from the Contractor in any specific dollar amounts or to request any work at all from the Contractor during any period of this Contract.

C.2. Compensation Firm. The payment rates and the maximum liability of the State under this Contract are firm for the duration of the Contract and are not subject to escalation for any reason unless amended.

C.3. Payment Methodology. The Contractor shall be compensated based on the payment rates herein for units of service authorized by the State in a total amount not to exceed the Contract Maximum Liability established in Section C.1.

a. The Contractor's compensation shall be contingent upon the satisfactory completion of units, milestones, or increments of service defined in Section A.

b. The Contractor shall be compensated based upon the following payment rates:

(1) For service performed from June 1, 2008 through December 31, 2010, the following rates shall apply, based upon the number of Enrollees certified by the Eligibility Determination Contractor to the Contractor;

	Distribution of Premium to Administration and Benefits Component	Premium Rates In effect from June 1, 2008-Dec. 31, 2008	Premium Rates In effect from Jan. 1, 2009-Dec. 31, 2009	Premium Rates In effect from Jan. 1, 2010-Dec. 31, 2010
Group One Child (monthly) [1]	Amount of Premium	$17.17	$18.51	$19.77
	Amount of Premium for Administration	$1.62	$1.71	$1.80
Group Two Child (monthly) [2]	Amount of Premium	$14.20	$15.16	$16.05
	Amount of Premium for Administration	$1.47	$1.54	$1.62
AI/AN Child (monthly) [3]	Amount of Premium	$15.18	$16.21	$17.31
	Amount of Premium for Administration	$1.52	$1.60	$1.68

[1] Group One Child is defined as a covered child who is in a family with an income at or above 150 percent of FPL.
[2] Group Two Child is defined as a covered child who is in a family with an income below 150 percent of FPL and therefore subject to reduced copayments.
[3] AI/AN Child is defined as a covered child who is (a) certified American Indian/Alaskan Native (AI/AN) and (b) a member of a family with an income less than or equal to 250 percent of the FPL, as reported by the Eligibility Determination Contractor to the Contractor for the coverage period.

c. In the event that the coverage of an Enrollee is terminated on a retroactive basis, the State shall reimburse any claims payments made by the Contractor for services rendered during the period of the retroactive cancellation.

(1) If this Contract is extended pursuant to Section B.2., the following shall apply. For service performed from January 1, 2011, through December 31, 2011 the Contractor shall be compensated based upon the payment rates in Section C.3.b. (1) above but adjusted by the percentage increase, if any, between the Consumer Price Index for All Urban Consumers (CPI-U): U.S. city average, Dental Services, not seasonally adjusted, index base period: 1982-84=100), published by the United States Department of Labor, Bureau of Labor Statistics (or its successor index) in August, 2010 and that figure published in the same month, 12-months prior.

(2) If this Contract is extended pursuant to Section B.2., the following shall apply. For service performed from January 1, 2012, through December 31, 2012, the Contractor shall be compensated based upon the payment rates in Section C.3.b. (1) above but adjusted by the percentage increase, if any, between the Consumer Price Index for All Urban Consumers (CPI-U): U.S. city average, Dental Services, not seasonally adjusted, index base period: 1982-84=100), published by the United States Department of Labor, Bureau

of Labor Statistics (or its successor index) in August, 2011 and that figure published in the same month, 12-months prior.

(3) For the purpose of the payment amounts detailed in this Section, the premium for children and for low income children will be payable on a monthly basis for each month of coverage (a month is defined as the first day of a month to the last day of the month).

C.4. Travel Compensation. The Contractor shall not be compensated or reimbursed for travel, meals, or lodging.

C.5. Invoice Requirements. The Contractor shall invoice the State only for completed increments of service and for the amount stipulated in Section C.3, above, and as required below prior to any payment.

a. The Contractor shall submit invoices no more often than monthly, with all necessary supporting documentation, to:

Department of Finance and Administration
Benefits Administration
2600 WRS Tennessee Tower
312 8th Avenue, North
Nashville, TN 37243

b. The Contractor agrees that each invoice submitted shall clearly and accurately (all calculations must be extended and totaled correctly) detail the following required information.

(1) Invoice/Reference Number (assigned by the Contractor);
(2) Invoice Date;
(3) Invoice Period (period to which all invoiced charges are applicable);
(4) Contract Number (assigned by the State to this Contract);
(5) Account Name: Department of Finance and Administration, Benefits Administration;
(6) Account/Customer Number (uniquely assigned by the Contractor to the above-referenced Account Name);
(7) Contractor Name;
(8) Contractor Federal Employer Identification Number or Social Security Number (as referenced in this Contract);
(9) Contractor Contact (name, phone, and/or fax for the individual to contact with billing questions);
(10) Contractor Remittance Address;
(11) Complete Itemization of Charges, which shall detail the following:

i. Service or Milestone Description (including name /title as applicable) of each service invoiced;
ii. Number of Completed Units, Increments, Hours, or Days as applicable, of each service invoiced;
iii. Applicable Payment Rate (as stipulated in Section C.3.) of each service invoiced;
iv. Amount Due by Service; and
v. Total Amount Due for the invoice period.

c. The Contractor understands and agrees that an invoice to the State under this Contract shall:

(1) include only charges for service described in Contract Section A and in accordance with payment terms and conditions set forth in Contract Section C;
(2) not include any future work but will only be submitted for completed service; and
(3) not include sales tax or shipping charges.

d. The Contractor agrees that timeframe for payment (and any discounts) begins when the State is in receipt of each invoice meeting the minimum requirements above.

e. The Contractor shall complete and sign a "Substitute W-9 Form" provided to the Contractor by the State. The taxpayer identification number contained in the Substitute W-9 submitted to the State shall agree to the Federal Employer Identification Number or Social Security Number referenced in this Contract for the Contractor. The Contractor shall not invoice the State for services until the State has received this completed form.

C.6. Payment of Invoice. The payment of the invoice by the State shall not prejudice the State's right to object to or question any invoice or matter in relation thereto. Such payment by the State shall neither be construed as acceptance of any part of the work or service provided nor as an approval of any of the amounts invoiced therein.

C.7. Invoice Reductions. The Contractor's invoice shall be subject to reduction for amounts included in any invoice or payment theretofore made which are determined by the State, on the basis of audits conducted in accordance with the terms of this Contract, not to constitute proper remuneration for compensable services.

C.8. Deductions. The State reserves the right to deduct from amounts which are or shall become due and payable to the Contractor under this or any Contract between the Contractor and the State of Tennessee any amounts which are or shall become due and payable to the State of Tennessee by the Contractor.

C.9. Automatic Deposits. The Contractor shall complete and sign an "Authorization Agreement for Automatic Deposit (ACH Credits) Form." This form shall be provided to the Contractor by the State. Once this form has been completed and submitted to the State by the Contractor all payments to the Contractor, under this or any other Contract the Contractor has with the State of Tennessee shall be made by Automated Clearing House (ACH). The Contractor shall not invoice the State for services until the Contractor has completed this form and submitted it to the State.

D. STANDARD TERMS AND CONDITIONS:

D.1. Required Approvals. The State is not bound by this Contract until it is approved by the appropriate State officials in accordance with applicable Tennessee State laws and regulations.

D.2. Modification and Amendment. This Contract may be modified only by a written amendment executed by all parties hereto and approved by the appropriate Tennessee State officials in accordance with applicable Tennessee State laws and regulations.

D.3. Termination for Convenience. The State may terminate this Contract without cause for any reason. Said termination shall not be deemed a Breach of Contract by the State. The State shall give the Contractor at least ninety (90) days written notice before the effective termination date. The Contractor shall be entitled to receive compensation for satisfactory, authorized service completed as of the termination date, but in no event shall the State be liable to the Contractor for compensation for any service which has not been rendered. Upon such termination, the Contractor shall have no right to any actual general, special, incidental, consequential, or any other damages whatsoever of any description or amount.

D.4. Termination for Cause. If the Contractor fails to properly perform its obligations under this Contract in a timely or proper manner, or if the Contractor violates any terms of this Contract, the State shall have the right to terminate the Contract and withhold payments in excess of fair compensation for completed services. The State will provide notification of termination for cause in writing. This notice will (1) specify in reasonable detail the nature of the breach; (2) provide Contractor with an opportunity to cure, which must be requested in writing no less than 10 days from the date of the Termination Notice; and (3) shall specify the effective date of termination in the event Contractor fails to correct the breach. Contractor must present the State with a written request detailing the efforts it will take to resolve the problem and the time period for such resolution. This opportunity to "cure" shall not apply to circumstances in which the Contractor intentionally withholds its services or otherwise refuses to perform. The State will not consider a request to cure contract performance where there have been repeated problems with respect to identical or similar issues, or if a cure period would cause a delay that would impair the effectiveness of State operations. In circumstances where an opportunity to cure is not available, termination will be effective immediately.

D.5. Termination for Cause. If the Contractor fails to properly perform its obligations under this Contract in a timely or proper manner, or if the Contractor violates any terms of this Contract, the State shall have the right to immediately terminate the Contract and withhold payments in excess of fair compensation for completed services. Notwithstanding the above, the Contractor shall not be relieved of liability to the State for damages sustained by virtue of any breach of this Contract by the Contractor.

D.5. Subcontracting. The Contractor shall not assign this Contract or enter into a subcontract for any of the services performed under this Contract without obtaining the prior written approval of the State. If such subcontracts are approved by the State, they shall contain, at a minimum, sections of this Contract below pertaining to "Conflicts of Interest," "Nondiscrimination," and "Records" (as identified by the section headings). Notwithstanding any use of approved subcontractors, the Contractor shall be the prime contractor and shall be responsible for all work performed.

D.6. Conflicts of Interest. The Contractor warrants that no part of the total Contract Amount shall be paid directly or indirectly to an employee or official of the State of Tennessee as wages, compensation, or gifts in exchange for acting as an officer, agent, employee, subcontractor, or consultant to the Contractor in connection with any work contemplated or performed relative to this Contract.

D.7. Nondiscrimination. The Contractor hereby agrees, warrants, and assures that no person shall be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the performance of this Contract or in the employment practices of the Contractor on the grounds of disability, age, race, color, religion, sex, national origin, or any other classification protected by Federal, Tennessee State constitutional, or statutory law. The Contractor shall, upon request, show proof of such nondiscrimination and shall post in conspicuous places, available to all employees and applicants, notices of nondiscrimination.

D.8. Prohibition of Illegal Immigrants. The requirements of Public Acts of 2006, Chapter Number 878, of the state of Tennessee, addressing the use of illegal immigrants in the performance of any Contract to supply goods or services to the state of Tennessee, shall be a material provision of this Contract, a breach of which shall be grounds for monetary and other penalties, up to and including termination of this Contract.

a. The Contractor hereby attests, certifies, warrants, and assures that the Contractor shall not knowingly utilize the services of an illegal immigrant in the performance of this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant in the performance of this Contract. The Contractor shall reaffirm this attestation, in writing, by submitting to the State a completed and signed copy of the document at Attachment 1, hereto, semi-annually during the period of this Contract. Such attestations shall be maintained by the Contractor and made available to state officials upon request.

b. Prior to the use of any subcontractor in the performance of this Contract, and semi-annually thereafter, during the period of this Contract, the Contractor shall obtain and retain a current, written attestation that the subcontractor shall not knowingly utilize the services of an illegal immigrant to perform work relative to this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant to perform work relative to this Contract. Attestations obtained from such subcontractors shall be maintained by the Contractor and made available to state officials upon request.

c. The Contractor shall maintain records for all personnel used in the performance of this Contract. Said records shall be subject to review and random inspection at any reasonable time upon reasonable notice by the State.

d. The Contractor understands and agrees that failure to comply with this section will be subject to the sanctions of Public Chapter 878 of 2006 for acts or omissions occurring after its effective date. This law requires the Commissioner of Finance and Administration to prohibit a contractor from contracting with, or submitting an offer, proposal, or bid to contract with the State of Tennessee to supply goods or services for a period of one year after a contractor is discovered to have knowingly used the services of illegal immigrants during the performance of this Contract.

e. For purposes of this Contract, "illegal immigrant" shall be defined as any person who is not either a United States citizen, a Lawful Permanent Resident, or a person whose physical presence in the United States is authorized or allowed by the federal Department of Homeland Security and who, under federal immigration laws and/or regulations, is authorized to be employed in the U.S. or is otherwise authorized to provide services under the Contract.

D.9. Records. The Contractor shall maintain documentation for all charges under this Contract. The books, records, and documents of the Contractor, insofar as they relate to work performed or money received under this Contract, shall be maintained for a period of three (3) full years from the date of the final payment and shall be subject to audit at any reasonable time and upon reasonable notice by the State, the Comptroller of the Treasury, or their duly appointed representatives. The financial statements shall be prepared in accordance with generally accepted accounting principles.

D.10. Monitoring. The Contractor's activities conducted and records maintained pursuant to this Contract shall be subject to monitoring and evaluation by the State, the Comptroller of the Treasury, or their duly appointed representatives.

D.11. Progress Reports. The Contractor shall submit brief, periodic, progress reports to the State as requested.

D.12. Strict Performance. Failure by any party to this Contract to insist in any one or more cases upon the strict performance of any of the terms, covenants, conditions, or provisions of this Contract shall not be construed as a waiver or relinquishment of any such term, covenant, condition, or provision. No term or condition of this Contract shall be held to be waived, modified, or deleted except by a written amendment signed by the parties hereto.

D.13. Independent Contractor. The parties hereto, in the performance of this Contract, shall not act as employees, partners, joint venturers, or associates of one another. It is expressly acknowledged by the parties hereto that such parties are independent contracting entities and that nothing in this Contract shall be construed to create an employer/employee relationship or to allow either to exercise control or direction over the manner or method by which the other transacts its business affairs or provides its usual services. The employees or agents of one party shall not be deemed or construed to be the employees or agents of the other party for any purpose whatsoever.

The Contractor, being an independent contractor and not an employee of the State, agrees to carry adequate public liability and other appropriate forms of insurance, including adequate public liability and other appropriate forms of insurance on the Contractor's employees, and to pay all applicable taxes incident to this Contract.

D.14. State Liability. The State shall have no liability except as specifically provided in this Contract.

D.15. Force Majeure. The obligations of the parties to this Contract are subject to prevention by causes beyond the parties' control that could not be avoided by the exercise of due care including, but not limited to, acts of God, natural disasters, riots, wars, epidemics or any other similar cause.

D.16. State and Federal Compliance. The Contractor shall comply with all applicable State and Federal laws and regulations in the performance of this Contract.

D.17. Governing Law. This Contract shall be governed by and construed in accordance with the laws of the State of Tennessee. The Contractor agrees that it will be subject to the exclusive jurisdiction of the courts of the State of Tennessee in actions that may arise under this Contract. The Contractor acknowledges and agrees that any rights or claims against the State of Tennessee or its employees hereunder, and any remedies arising therefrom, shall be subject to and limited to those rights and remedies, if any, available under *Tennessee Code Annotated*, Sections 9-8-101 through 9-8-407.

D.18. Completeness. This Contract is complete and contains the entire understanding between the parties relating to the subject matter contained herein, including all the terms and conditions of the parties' agreement. This Contract supersedes any and all prior understandings, representations, negotiations, and agreements between the parties relating hereto, whether written or oral.

D.19. Severability. If any terms and conditions of this Contract are held to be invalid or unenforceable as a matter of law, the other terms and conditions hereof shall not be affected thereby and shall remain in full force and effect. To this end, the terms and conditions of this Contract are declared severable.

D.20. Headings. Section headings of this Contract are for reference purposes only and shall not be construed as part of this Contract.

E. SPECIAL TERMS AND CONDITIONS:

E.1. Conflicting Terms and Conditions. Should any of these special terms and conditions conflict with any other terms and conditions of this Contract, these special terms and conditions shall control.

E.2. Communications and Contacts. All instructions, notices, consents, demands, or other communications required or contemplated by this Contract shall be in writing and shall be made by certified, first class mail, return receipt requested and postage prepaid, by overnight courier service with an asset tracking system, or by EMAIL or facsimile transmission with recipient confirmation. Any such communications, regardless of method of transmission, shall be addressed to the respective party at the appropriate mailing address, facsimile number, or EMAIL address as set forth below or to that of such other party or address, as may be hereafter specified by written notice.

The State:

Ms. Marlene D. Alvarez, Manager of Procurements and Contracts
Department of Finance and Administration, Benefits Administration
312 8th Avenue North,
26th Floor, WRS Tennessee Tower
Nashville, TN 37243
Phone: 615.253.8358
Fax: 615.253.8556
Email Address: Marlene.Alvarez@state.tn.us

The Contractor:

David Allen, FSA, MAAA, Assistant Vice President and Actuary
National Guardian Life Insurance Company
Two E. Gilman St.
Madison, WI 53703
Telephone Number: 608-443-5277
Fax Number: 608-257-1808
Email Address: djallen@nglic.com

All instructions, notices, consents, demands, or other communications shall be considered effectively given upon receipt or recipient confirmation as may be required.

E.3. Subject to Funds Availability. The Contract is subject to the appropriation and availability of State and/or Federal funds. In the event that the funds are not appropriated or are otherwise unavailable, the State reserves the right to terminate the Contract upon written notice to the Contractor. Said termination shall not be deemed a breach of Contract by the State. Upon receipt of the written notice, the Contractor shall cease all work associated with the Contract. Should such an event occur, the Contractor shall be entitled to compensation for all satisfactory and authorized services completed as of the termination date. Upon such termination, the Contractor shall have no right to recover from the State any actual, general, special, incidental, consequential, or any other damages whatsoever of any description or amount.

E.4. Tennessee Consolidated Retirement System. The Contractor acknowledges and understands that, subject to statutory exceptions contained in *Tennessee Code Annotated*, Section 8-36-801, *et. seq.*, the law governing the Tennessee Consolidated Retirement System (TCRS), provides that if a retired member of TCRS, or of any superseded system administered by TCRS, or of any local retirement fund established pursuant to *Tennessee Code Annotated*, Title 8, Chapter 35, Part 3 accepts state employment, the member's retirement allowance is suspended during the period of the employment. Accordingly and

notwithstanding any provision of this Contract to the contrary, the Contractor agrees that if it is later determined that the true nature of the working relationship between the Contractor and the State under this Contract is that of "employee/employer" and not that of an independent contractor, the Contractor may be required to repay to TCRS the amount of retirement benefits the Contractor received from TCRS during the period of this Contract.

E.5. Confidentiality of Records. Strict standards of confidentiality of records shall be maintained in accordance with the law. All material and information, regardless of form, medium or method of communication, provided to the Contractor by the State or acquired by the Contractor on behalf of the State shall be regarded as confidential information in accordance with the provisions of State law and ethical standards and shall not be disclosed, and all necessary steps shall be taken by the Contractor to safeguard the confidentiality of such material or information in conformance with State law and ethical standards.

The Contractor will be deemed to have satisfied its obligations under this section by exercising the same level of care to preserve the confidentiality of the State's information as the Contractor exercises to protect its own confidential information so long as such standard of care does not violate the applicable provisions of the first paragraph of this section.

The Contractor's obligations under this section do not apply to information in the public domain; entering the public domain but not from a breach by the Contractor of this Contract; previously possessed by the Contractor without written obligations to the State to protect it; acquired by the Contractor without written restrictions against disclosure from a third party which, to the Contractor's knowledge, is free to disclose the information; independently developed by the Contractor without the use of the State's information; or, disclosed by the State to others without restrictions against disclosure.

It is expressly understood and agreed the obligations set forth in this section shall survive the termination of this Contract.

E.6. HIPAA Compliance. The State and Contractor shall comply with obligations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its accompanying regulations.

a. Contractor warrants to the State that it is familiar with the requirements of HIPAA and its accompanying regulations, and will comply with all applicable HIPAA requirements in the course of this Contract.

b. Contractor warrants that it will cooperate with the State, including cooperation and coordination with State privacy officials and other compliance officers required by HIPAA and its regulations, in the course of performance of the Contract so that both parties will be in compliance with HIPAA.

c. The State and the Contractor will sign documents, including but not limited to business associate agreements, as required by HIPAA and that are reasonably necessary to keep the State and Contractor in compliance with HIPAA. This provision shall not apply if information received by the State under this Contract is NOT "protected health information" as defined by HIPAA, or if HIPAA permits the State to receive such information without entering into a business associate agreement or signing another such document. See Contract Attachment 6.

MDG/KW 4-2-08 C MDG 4-2-08 DJA 4/1/08

MDG/KW 4-2-08 MDG 4-2-08 DJA 4/1/08

E.7. Incorporation of Additional Documents. Included in this Contract by reference are the following documents:

a. The Contract document and its attachments

b. All Clarifications and addenda made to the Contractor's Proposal

c. The Request for Proposal and its associated amendments

d. Technical Specifications provided to the Contractor

e. The Contractor's Proposal

In the event of a discrepancy or ambiguity regarding the Contractor's duties, responsibilities, and performance under this Contract, these documents shall govern in order of precedence detailed above.

IN WITNESS WHEREOF:

NATIONAL GUARDIAN LIFE INSURANCE COMPANY:

	3-12-2008
CONTRACTOR SIGNATURE	**DATE**
JOHN D. LARSON CHAIRMAN, PRESIDENT & C.E.O.	
PRINTED NAME AND TITLE OF AUTHORIZED CONTRACTOR SIGNATORY (above)	

DEPARTMENT OF FINANCE AND ADMINISTRATION:

	3-18-08
M. D. GOETZ, JR., COMMISSIONER	**DATE**

APPROVED:

M.D. Goetz, Jr. /KW	APR 0 2 2008
M. D. GOETZ, JR., COMMISSIONER DEPARTMENT OF FINANCE AND ADMINISTRATION	**DATE**
John G. Morgan	4/9/08
JOHN G. MORGAN, COMPTROLLER OF THE TREASURY	**DATE**

ATTESTATION RE PERSONNEL USED IN CONTRACT PERFORMANCE

SUBJECT CONTRACT NUMBER:	**FA-08-**
CONTRACTOR LEGAL ENTITY NAME:	**NATIONAL GUARDIAN LIFE INSURANCE COMPANY**
FEDERAL EMPLOYER IDENTIFICATION NUMBER: (or Social Security Number)	**39-0493780**

The Contractor, identified above, does hereby attest, certify, warrant, and assure that the Contractor shall not knowingly utilize the services of an illegal immigrant in the performance of this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant in the performance of this Contract.

CONTRACTOR SIGNATURE

NOTICE: This attestation MUST be signed by an individual empowered to contractually bind the Contractor. If said individual is not the chief executive or president, this document shall attach evidence showing the individual's authority to contractually bind the Contractor.

JOHN D. LARSON CHAIRMAN, PRESIDENT & C.E.O.

PRINTED NAME AND TITLE OF SIGNATORY

3-12-2008

DATE OF ATTESTATION

Performance Guarantees

The Contractor shall pay to the State the indicated total dollar assessment upon notification by the State that an amount is due, through the life of the Contract.

1. Claims Payment Dollar Accuracy	
Guarantee	The average quarterly financial accuracy for claims payments will be 99% or higher.
Definition	Claims Payment Dollar Accuracy is defined as the absolute value of financial errors, inclusive of both human and system generated, divided by the total paid value of Contractor audited dollars paid.
Assessment	**$500** for each full percentage point below 98% for each contracted quarter.
Compliance report	The Compliance Report is the quarterly internal audit performed by the Contractor on a statistically valid sample of claims. The Contractor shall measure and report results quarterly for the life of the contract. Performance will be reconciled annually on a calendar year basis.
2. Claims Processing Accuracy	
Guarantee	The average quarterly processing accuracy will be 97% or higher.
Definition	Claims Processing Accuracy is defined as the absolute number of claims with no in processing or procedural errors, divided by the total number of claims within the audit sample. This excludes financial errors.
Assessment	**$1000** for each full percentage point below 99%, for each contracted quarter.
Compliance report	The Compliance Report is the quarterly internal audit performed by the Contractor on a statistically valid sample of claims agreed upon by both parties prior to commencement. The Contractor shall measure and report results quarterly. Performance will be reconciled annually on a calendar year basis.
3. Claims Turnaround Time	
Guarantee	The average quarterly claims payment turnaround time will not be greater than: 30 business days for 97% of all claims.
Definition	Claims Turnaround Time is measured from the date the claim is received in the office to the date processed, including weekends and holidays.
Assessment	**$500** for each full percentage point below the required minimum standard of 90% for all claims.
Compliance report	The Compliance Report is the quarterly internal audit performed by the Contractor on a statistically valid sample agreed upon by both parties prior to commencement. The Contractor shall measure and report results quarterly for the life of the contract. Performance will be reconciled annually on a calendar year basis.
4. Telephone Response Time	
Guarantee	Average Speed of Answer (ASA) by a live member services representative of incoming Enrollee services calls will be 30 seconds or less.
Definition	Average Speed of Answer (ASA) is defined as the amount of time elapsing between the time a call is received into the phone system and when a live member services representative answers the phone.
Assessment	**$250** for each full second over the 30 second benchmark. Quarterly guarantee.
Compliance report	The Compliance Report is the Contractor's internal telephone support system reports. Performance will be measured quarterly through the life of the contract; reported and reconciled annually on a calendar year basis.
5. Enrollee Satisfaction	
Guarantee	The level of overall customer satisfaction, as measured annually by a State approved Enrollee Satisfaction survey(s), will be equal to or greater than 85% in the first year of the Contract, and 90% in all subsequent year(s) within the Contract term.
Definition	Participant Satisfaction will be measured utilizing the most current National Committee on Quality Assurance (NCQA) Adult Participant Satisfaction Survey question that measures overall satisfaction.
Assessment	**$3,000**. Annual guarantee.
Compliance report	The Compliance Report is the Contractor's results from National Committee Quality Assurance (NCQA) annual Adult Participant Satisfaction Survey. Performance will be measured, reported, and reconciled annually on a calendar year basis.
6. Member Handbooks and Provider Network Directories Distributed	
Guarantee	Member Handbooks and Provider Network Directories will be distributed to Enrollees within 14 calendar days of the effective date of enrollment or to individuals requesting information within five (5) business days of the request. (The handbook and provider directory may be a single document).
Definition	Member Handbook and Provider Network Directories will be measured based on date of distribution.
Assessment	Should either of the above listed documents not be distributed as required, the total assessment shall be **$2,500** per year in which the standard is not met.
Compliance report	The Compliance Report reported by Benefits Administration operations. Annual guarantee is measured, reported, and reconciled annually on a calendar year basis.

7. Provider Network Accessibility		
Guarantee	As measured by the GeoNetworks® Provider Network Accessibility Analysis, the Contractor's provider and facility network will assure that during the first phase of the performance guarantee implementation period, 85% of all Enrollees will have the Access Standard indicated below at the end of the first twelve (12) months of the contract effective date.	
Definition	**Provider Group**	**Access Standard**
	General or Pediatric Dentists	One (1) provider within 30 miles
	Dental Specialists	One (1) provider within 45 miles
Assessment	**$5,000** if either of the above listed standards is not met, either individually or in combination measured annually at the State's discretion.	
Guarantee	As measured by the GeoNetworks® Provider Network Accessibility Analysis, the Contractor's provider and facility network will assure that during the second phase of the performance guarantee implementation period, 90% of all Enrollees will have the Access Standard indicated below at the end of the second calendar year of the contract effective date and at the end of each successive calendar year.	
Definition	**Provider Group**	**Access Standard**
	General or Pediatric Dentists	Two (2) provider within 30 miles
	Dental Specialists	Two (2) provider within 45 miles
Compliance report	Compliance report is the annual GeoNetworks Analysis submitted by Contractor. The Annual guarantee is measured, reported and reconciled annually on a calendar year basis.	
Assessment	**$5,000** if either of the above listed standards is not met, either individually or in combination measured annually at the State's discretion.	
8. Claims Data Quality		
Guarantee	Claims Data Quality is measured by the State's Claims Data Management vendor Thomson Healthcare (Medstat). The Contractor's quarterly data submission to Thomson Healthcare (Medstat) must meet the following Data Quality measures.	
Definition	*Measure*	*Benchmark*
	Gender	Data missing for </= (less than or equal to) 3% of claims
	Date of birth	Data missing for </= 3% of claims
	Outpatient diagnosis coding	Data invalid or missing for </= 5% of outpatient claims
	Outpatient provider type missing	Data missing for </= 1.5% of outpatient claims
Assessment	**$2500** if any of the above listed standards is not met, either individually or in combination. Quarterly Guarantee.	
Compliance report	Compliance Report consists of the Thomson Healthcare (Medstat) Quarterly Data Quality report provided by Thomson Healthcare (Medstat). Performance measured and reported by Thomson Healthcare (Medstat) quarterly; reconciled annually on a calendar year basis.	
9. Submission of Quarterly Data to Data Management Vendor		
Guarantee	Quarterly claims data will be submitted by the Contractor to the state's data management vendor Thomson Healthcare (Medstat) no later than the last day of the month following the end of each calendar quarter.	
Definition	Quarterly claims data are received by Thomson Healthcare (Medstat) no later than the last day of the month following the end of each calendar quarter.	
Assessment	Failure to submit quarterly claims data no later than the last day of the month following the end of each quarter will result in an assessment of **$100** per day for the first and second working days past the compliance date, and **$500** for each working day thereafter, to a maximum of **$10,000** per quarter.	
Compliance report	Compliance reporting submitted by Thomson Healthcare (Medstat) upon receipt of quarterly claims data. Performance is measured, reported, and reconciled quarterly.	
10. Member ID Card Distribution		
Guarantee	Member ID cards must be distributed (defined as "mailed") to a minimum of 98% of Enrollees within 14 calendar days of the receipt of enrollment information.	
Definition	The actual distribution of member ID cards to 98% of all Enrollees by the specified dates.	
Assessment	Should the above standard not be met, the total amount shall be **$15,000** per year in which the standard is not met.	
Compliance report	Compliance Report submitted by Contractor. Performance is measured, reported, and reconciled annually on a calendar year basis.	

Contract Attachment 3
Quarterly Management Reporting Requirements

As required by Contract Section A.10., the Contractor shall submit Management Reports by which the State can assess the CoverKids Dental program costs and usage, as well as results in meeting the Performance Guarantee requirements as contained in Contract Attachment 2. Reports shall be submitted in hard copy medium. Management Reports shall include:

1) **Performance Guarantee Tracking**, as detailed at Contract Attachment 2 (each component to be submitted at the frequency indicated), shall include:

   - Status report narrative
   - Detail report on each performance measure by appropriate time period

- **CoverKids Dental Benefit Savings and Payments,** must be submitted as follows distinguishing between in-network and out-of-network:

GROUP ONE CHILD

Type of Service	Number of Services	Submitted Charge	Allowed Amount	Network Savings	Patient Payment	Plan Benefit
Preventive						
Diagnostic						
Emergency						
Restorative						
Simple Extractions						
Radiographs						
Therapeutic Pulpotomy						
Total						

GROUP TWO CHILD

Type of Service	Number of Services	Submitted Charge	Allowed Amount	Network Savings	Patient Payment	Plan Benefit
Preventive						
Diagnostic						
Emergency						
Restorative						
Simple Extractions						
Radiographs						
Therapeutic Pulpotomy						
Total						

AMERICAN INDIAN/ ALASKAN NATIVE CHILD

Type of Service	Number of Services	Submitted Charge	Allowed Amount	Network Savings	Patient Payment	Plan Benefit
Preventive						
Diagnostic						
Emergency						
Restorative						
Simple Extractions						
Radiographs						
Therapeutic Pulpotomy						
Total						

3) **Network and Out-of-Network by:**
   - Submitted charges
   - Benefits Paid
   - Member Utilization

4) **Summary Plan Information:**

Premium Category	Subscribers	Premium	Total Claims
Group One Child			
Group Two Child			
American Indian/ Alaskan Native Child			
Total			

5) **Quarterly Network Changes Update Report, displaying the following:**
   - Present Network of Participating Providers by Specialty
   - Additions to the Network by Name, Specialty and Location
   - Terminations to the Network by Name, Specialty and Location
   - Targeted areas for recruitment

Functional Specifications for File Layout

DESCRIPTION/GENERAL INFORMATION

This interface is designed to produce a Medical claims file for plan participants administered through **<Data Supplier>**.
The data will be provided in a fixed-record length, ASCII file format. The data request consists of two layouts/records; A Medical Detail Record and a Trailer Record.

METHOD OF SUBMISSION
[To be determined] Medstat supports a number of file submission options including: FTP, Web Submission, as well as physical media.

FREQUENCY OF SUBMISSION
The data will be submitted to Medstat on a **<monthly/quarterly>** basis.

TIMING OF SUBMISSION
<Monthly/Quarterly> files should be submitted on or before the 15th of the month following the close of each **<month/quarter>**.

Data Type: Medical Claims / Encounter Records

Definitions:

- **Fee-for-service claims** – Claims records for services that result in direct payment to providers on a service-specific basis.
- **Encounter records** – Utilization records for services provided under capitation arrangements (i.e., plans in which a provider is paid based on the number of enrollees rather than the services rendered.) These records enable documentation of all services provided regardless of whether or not direct payment was made to the provider.
- **Facility Data** – Facility data includes all services rendered by an inpatient or outpatient facility. The basis for the requirements of facility data is the information found on the standard UB-92 claim form.
- **Professional Data** – Professional data includes all services rendered by a physician or other professional provider, including dental, vision and hearing. The basis for the requirements of professional data is the information found on the standard CMS-1500 claim form.
- **Fee-for-Service Equivalents** – Financial amounts for services rendered under a capitated arrangement found within encounter records.

Items for discussion

General

- If both fee-for-service claims and encounter records are included on the data file, Medstat will rely on the data supplier to explain how to differentiate them.
- Medstat prefers to receive the facility, professional and capitation data (if applicable) in one file. We will rely on the data supplier to explain how to differentiate facility, professional and capitation services in their data.
- If encounter records contain fee-for-service equivalents, it is essential for Medstat to understand which fields contain these amounts.
- Financial fields should be populated at the service line level, not at the claim level.
- Medstat will need to understand the circumstances under which claims are not paid on a line item basis. For example, situations where claims are paid on a per diem basis or paid based on a DRG.
- If the managed care program includes a risk-sharing arrangement with providers such that a portion of the approved payment amount is withheld from the provider payment and placed in a risk-sharing pool for

later distribution, then the withhold amount should be recorded as a separate field and also included in the Charge Submitted, Allowed Amount and Net Payment fields.

Financial Fields
Medstat defines the relationship among financial fields as follows:

Charge Submitted
– Not Covered Amount*
= Charge Covered*
– Discount Amount
= Allowed Amount
– Coinsurance
– Copayment
– Deductible
– Penalty/Sanction Amount*
– Third Party Amount
= Net Payment

*not required in standard data extract (desirable if available)

Corrections to paid claims

Data suppliers generally use either Void/Replacement or Adjustment records to make corrections to paid claims. Medstat defines these as follows:

Void/Replacement
A void is a claim that reverses or backs out a previously paid one. All financials and quantities are negated on the void record. A replacement record that contains the corrected information generally follows it.
The original, void and replacement need not appear in the same file.

Example: After adjudication, a paid claim with a $25 Copayment and $50 Net Pay, a correction was necessary. The correction contains a $10 Copayment and $65 Net Pay.

Record Type	Service Count	Charge Submitted	Copayment	Deductible	Net Payment
Original	1	75.00	25.00	0.00	50.00
Void	-1	-75.00	-25.00	0.00	-50.00
Replacement	1	75.00	10.00	0.00	65.00

Adjustments
A financial adjustment is a claim line where one or more of the financial fields display the difference between the original amount and the final amount. Any financial not being adjusted should be zero. All quantities should be zero on the adjustment as well.
The original and adjustment need not appear in the same file.
Example: After a claim was adjudicated with a $25 Copayment and $50 Net Pay, it was discovered that there should have been a $10 Copayment and $65 Net Pay.

Record Type	Service Count	Charge Submitted	Copayment	Deductible	Net Payment
Original	1	75.00	25.00	0.00	50.00
Adjustment	0	0	-15.00	0.00	15.00

Facility Record Content

- The standard UB-92 claim form contains both information that pertains to the entire claim and single service/procedure within the claim.
- Each record in the data file should represent one service (detail) line.

- All financials and quantities on each record should pertain to that service only (as opposed to the entire claim).
- The repeating of non-quantitative claim-level information (e.g., Claim ID, Provider ID, Provider Type, etc.) on each record is necessary.

Example: One facility claim with three service lines:

Claim-Level Information			Service-Level Detail			
Claim ID	Prov ID	Prov Type	Line Nbr	Rev Cd	Svc Cnt	Net Pay
11111	121212121	25	1	120	2	2000.00
11111	121212121	25	2	250	1	100.00
11111	121212121	25	3	720	10	1532.00

Professional Record Content

- Medstat does not store separate header/claim-level and detail/service-level information for professional claims. Medstat requires the following:
- Each record in the data file should represent one service (detail) line.
- All financials and quantities on each record should pertain to that service only (as opposed to the entire claim.)
- The repeating of non-quantitative claim-level information (e.g., Claim ID, Provider ID, Provider Type, etc.) on each record is necessary.

Example: One professional claim with two service lines:

Claim-Level Information			Service-Level Detail			
Claim ID	Prov ID	Prov Type	Line Nbr	Proc Cd	Svc Cnt	Net Pay
13331	621262121	51	1	99201	1	100.00
13331	621262121	51	2	99175	1	150.00

Denied Claims

Fully denied claims should be removed from the extract of claims prior to submission, while partially denied claims should be included. Medstat defines denied claims as follows:

- Fully denied claim - The entire claim has been denied (typical reasons include an ineligible member, an ineligible provider, or a duplicate claims).
- Partially denied claim – The claim contains one or more service lines that are denied, but some that are paid. All service lines should be included on the file.

Data Type: Capitation Data

Definition

1 Capitation data contains information regarding payments made to a physician, facility or other provider for a pre-determined set of services, regardless if the services are rendered to the enrollee. When services are rendered, an encounter record will be found in the medical claims data.

Items for Discussion

- Person-level information is preferred; such as, one record contains payment information per person per month
- Provider detail information is also preferred

DATA FORMATTING

Character Fields

- Includes A - Z (lower or upper case), 0 – 9, and spaces
- Left justified, right blank/space filled
- Unrecorded or missing values in character fields are blank/spaces

Numeric Fields

- All numeric fields should be right-justified and left zero-filled.
- Unrecorded or missing values in numeric fields should be set to zero.

Financial Fields

- All financial fields should be right-justified and left zero-filled.
- Medstat prefers to receive both dollars and cents, with an implied decimal point before the last two digits in the data. For example, the data string "1234567" would represent $12,345.67. Please do not include an actual decimal point in the data.
- Unrecorded or missing values in numeric fields should be zero (000 to accommodate the 2-digit implied decimal) and left zero-filled.

Medical Record

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes
Standard Medstat Fields							
1	Adjustment Type Code	1	1	1	Character	Client-specific code for the claim adjustment type	Adjustment Type values will be identified in the **Data Dictionary.**
2	Allowed Amount	2	11	10	Numeric	The maximum amount allowed by the plan for payment.	Format 9(7)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
3	Bill Type Code UB	12	14	3	Character	The UB-92 standard code for the billing type, indicating type of facility, bill	Bill Type values will be identified in the **Data Dictionary.**
4	Capitated Service Indicator	15	15	1	Character	An indicator that this service (encounter record) was capitated	Applicable field values are "Y" for Capitated services and "N" for non-cap services.
5	Charge Submitted	16	25	10	Numeric	The submitted or billed charge amount	Format 9(7)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
6	Claim ID	26	40	15	Character	The client-specific identifier of the claim.	
7	Claim Type Code	41	42	2	Numeric	Client-specific code for the type of claim	Claim Type Codes will be identified in the **Data Dictionary.**
8	Co-Insurance	43	52	10	Numeric	The coinsurance paid by the subscriber as specified in the plan provision.	Format 9(7)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
9	Copayment	53	62	10	Numeric	The copayment paid by the subscriber as specified in the plan provision.	Format 9(7)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes
10	Date of Birth	63	72	10	Date	The birth date of the person.	MM/DD/CCYY format The member's birth date is part of the Person ID key and is, therefore, critical to tagging claims to eligibility. The four-digit year is required for date of birth. The century cannot be accurately assigned based on a two-digit year.
11	Date of First Service	73	82	10	Date	The date of the first service reported on the claim or authorization record.	MM/DD/CCYY format
12	Date of Last Service	83	92	10	Date	The date of the last service reported on the claim or authorization record.	MM/DD/CCYY format
13	Date of Service Facility Detail	93	102	10	Date	The date of service for the facility detail record.	MM/DD/CCYY format
14	Date Paid	103	112	10	Date	The date the claim or data record was paid.	MM/DD/CCYY format This is the check date.
15	Days	113	118	6	Numeric	The number of inpatient days for the facility claim.	
16	Deductible	119	128	10	Numeric	The amount paid by the subscriber through the deductible arrangement of the plan.	Format 9(7)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
17	Diagnosis Code Principal	129	133	5	Character	The first or principal diagnosis code for a service, claim or lab result.	No decimal point.
18	Diagnosis Code 2 UB	134	138	5	Character	A secondary diagnosis code for the facility claim.	No decimal point.
19	Diagnosis Code 3 UB	139	143	5	Character	A secondary diagnosis code for the facility claim.	No decimal point.
20	Diagnosis Code 4 UB	144	148	5	Character	A secondary diagnosis code for the facility claim.	No decimal point.
21	Diagnosis Code 5 UB	149	153	5	Character	A secondary diagnosis code for the facility claim.	No decimal point.
22	Diagnosis Code 6 UB	154	158	5	Character	A secondary diagnosis code for the facility claim.	No decimal point.
23	Diagnosis Code 7 UB	159	163	5	Character	A secondary diagnosis code for the facility claim.	No decimal point.

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes
24	Diagnosis Code 8 UB	164	168	5	Character	A secondary diagnosis code for the facility claim.	No decimal point.
25	Diagnosis Code 9 UB	169	173	5	Character	A secondary diagnosis code for the facility claim.	No decimal point.
26	Diagnosis Code 10 UB	174	178	5	Character	A secondary diagnosis code for the facility claim.	No decimal point.
27	Diagnosis Code 11 UB	179	183	5	Character	A secondary diagnosis code for the facility claim.	No decimal point.
28	Diagnosis Code 12 UB	184	188	5	Character	A secondary diagnosis code for the facility claim.	No decimal point.
29	Diagnosis Code 13 UB	189	193	5	Character	A secondary diagnosis code for the facility claim.	No decimal point.
30	Discharge Status Code UB	194	195	2	Numeric	The UB-92 standard patient status code, indicating disposition at the time of billing.	
31	Discount	196	205	10	Numeric	The discount amount of the claim, applied to charges for any plan pricing reductions.	Format 9(7)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
32	Family ID/Employee SSN	206	214	9	Character	The unique identifier (Social Security Number) for the subscriber (contract holder, employee) and their associated dependents.	The subscriber's social security number is part of the Person ID key and is, therefore, critical to tagging claims to eligibility.
33	Gender Code	215	215	1	Character	The member's gender code.	"M" or "F" The member's gender is part of the Person ID key and is, therefore, critical to tagging claims to eligibility.
34	Line Number	216	217	2	Numeric	The detail line number for the service on the claim	
35	Net Payment	218	227	10	Numeric	The actual check amount for the record	Format 9(7)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
36	Network Paid Indicator	228	228	1	Character	An indicator of whether the claim was paid at in-network or out-of-network level	"Y" or "N"

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes
37	Network Provider Indicator	229	229	1	Character	Indicates if the servicing provider participates in the network to which the patient belongs	"Y" or "N"
38	Ordering Provider ID	230	242	13	Character	The ID number of the provider who referred the patient or ordered the test or procedure.	The ID should be the physician's Federal Tax ID (TIN).
39	PCP Responsibility Indicator	243	243	1	Character	An indicator signifying that the PCP is the physician considered responsible or accountable for this claim.	
40	Place of Service Code	244	245	2	Character	Client-specific code for the place of service.	Place of Service values will be identified in the Data **Dictionary.**
41	Procedure Code	246	250	5	Character	The procedure code for the service record.	CPT/HCPCS codes.
42	Procedure Code UB Surg 1	251	255	5	Character	The primary surgical procedure code (1) on the facility claim.	ICD-9 Surgical procedure codes.
43	Procedure Modifier Code 1	256	257	2	Character	The 2-character code of the first procedure code modifier on the professional claim	
44	Provider ID	258	270	13	Character	The identifier for the provider of service.	This must be the federal tax ID in order to use the standard hospital identifier lookup (UNIHOSP)
45	Provider Type Code Claim	271	273	3	Numeric	Client-specific code for the provider type on the claim record	Provider Type codes are further defined in the **Data Dictionary**
46	Provider Zip Code	274	278	5	Numeric	The 5-digit zip code corresponding to the Provider ID	Provider Location zip code
47	Revenue Code UB	279	282	4	Numeric	The CMS standard revenue code from the facility claim	This field must be at the service/detail level.
48	Third Party Amount	283	292	10	Numeric	The amount saved due to integration of third party liability (Coordination of Benefits) by all third party payers (including Medicare).	Format 9(7)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
49	Units of Service	293	296	4	Numeric	Client-specific quantity of services or units	

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes
50	Provider Name	297	326	30	Character	The description or name corresponding to the Provider ID.	
51	Financial Cost Amount	327	336	10	Numeric	The amount of payments contributing to total cost of coverage, but received as a standard claim.	Format 9(7)v99 (2 – digit, implied decimal) Usually used for capitation payments.
52	Capitation Type Code	337	338	2	Numeric	Client-specific code for the type of capitation payment	
53	Funding Type Code	339	340	2	Numeric	Specifies whether the claim was paid under a fully or self-funded arrangement	"S" = Self-funded "F" = Fully-funded
54	Account Structure	341	348	8	Character	Client-specific code for the account structure of the plan that the member is enrolled in. This is usually a group number.	Additional fields may be added to the layout if there is more than one component of the account structure.
55	Provider NPI Number	349	358	10	Character	The National Provider ID number for the provider.	
56	Provider Address 1	359	408	50	Character	The current street address1 of the provider of service.	
57	Provider Address 2	409	458	50	Character	The current street address2 of the provider of service.	
58	HRA Amount	459	458	10	Numeric	The amount paid from the HRA as a result of this claim.	
58	Filler1	469	599	131	Character	Reserved for future use	Fill with blanks
59	Record Type	600	600	1	Character	Record Type Identifier	Hard Code 'D'

Medical Detail – Trailer Record

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instruction Notes
1	Data Start Date	1	10	10	Date	Data Start Date	MM/DD/CCYY format – i.e. 09/01/2004. This will represent the 1st day of the month for which data is provided.
2	Data End Date	11	20	10	Date	Data End Date	MM/DD/CCYY format – i.e. 09/30/2004 This will represent the last day of the month for which data is provided.
3	Record Count	21	30	10	Numeric	Number of Records on File	The count of records provided in the data excluding the Trailer Record
4	Total Net Payments	31	44	14	Numeric	Total Net Payments on File	The sum of Net Payments provided on the file.
5	Filler	45	599	555	Character	Filler	Fill with Blanks
6	Record Type	600	600	1	Character	Record Type Identifier	Hard Code 'T'

Dental Service Categories by Dental CDT Codes

Subject to a medical necessity determination by the Contractor, the following services must be covered by the dental coverage provided through CoverKids (subject to service and monetary limits specified in the *pro forma* contract Section A.4.).

DENTAL SERVICE CATEGORY	CDT CODES
PREVENTATIVE	
Prophylaxis Child	D1120
Topical Application of Fluoride-child	D1203
Topical fluoride varnish	D1206
Sealants	D1351
DIAGNOSTIC SERVICES	
Periodic Oral Examination	D0120
Comprehensive Oral Examination - new or established patient	D0150
EMERGENCY SERVICES	
Palliative (emergency) treatment of dental pain (minor procedure)	D9110
Office Visit (after regular office hours)	D9440
RESTORATIVE SERVICES	
Amalgam Restorations - Secondary and primary	
Amalgam One Surface, Primary or Permanent	D2140
Amalgam Two Surfaces, Secondary and primary	D2150
Amalgam Three Surfaces, Secondary and primary	D2160
Amalgam Four or More Surfaces, Primary or Permanent	D2161
Resin-Based Composite Restorations	
One Surface, Anterior	D2330
Two Surfaces, Anterior	D2331
Three Surfaces, Anterior	D2332
Four or More Surfaces or involving incisal angle (anterior)	D2335
One Surface, Posterior	D2391
Two Surface, Posterior	D2392
Three Surface, Posterior	D2393
Four or More Surfaces, Posterior	D2394
Crowns	
Recement Crown	D2920
Prefabricated stainless steel Crown (primary tooth)	D2930
Prefabricated stainless steel Crown (permanent tooth)	D2931
Prefabricated resin crown - Composite Crown	D2932

Stainless Steel Crown, with resin window	D2933
Sedative Fillings	D2940
Core buildup including pins	D2950
Pin retention - per tooth, in addition to restoration	D2951
Cast post and core, in addition to crown	D2952
Prefabricated post and core	D2954
Crown - porcelain/ceramic substrate	D2740
Crown - porcelain fused to high noble metal	D2750
Crown - porcelain fused to predominantly base metal	D2751
Crown - porcelain fused to noble metal	D2752
EXTRACTIONS	
Extraction, Erupted Tooth or Exposed Root	D7140
Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	D7210
Removal of impacted tooth - soft tissue	D7220
Removal of impacted tooth - partially bony	D7230
Removal of impacted tooth - completely bony	D7240
Surgical removal of residual tooth roots (cutting procedure)	D7250
Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth (health check)	D7270
Surgical access of an unerupted tooth (health check ONLY)	D7280
Placement of device to facilitate eruption of impacted tooth	D7283
Biopsy of oral tissue - hard	D7285
Biopsy of oral tissue - soft	D7286
RADIOGRAPHS	
Intraoral - Complete Series	D0210
Intraoral - First Film	D0220
Intraoral - Each Additional Film	D0230
Bitewing Single Film	D0270
Bitewing Two Films	D0272
Bitewing Four Films	D0274
Panoramic Film	D0330
THERAPEUTIC PULPOTOMY	
Pulpotomy - Therapeutic	D3220

Gross pulpal debridgement - primary and permanent	D3221
Pulpal therapy, anterior -primary	D3230
Pulpal therapy, posterior -primary	D3240
ANESTHESIA	
Deep Sedation/General Anesthesia-first 30 minutes	D9220
Deep Sedation/General Anesthesia, each additional 15 minutes	D9221
Analgesia, anxiolysis, inhalation of nitrous oxide (prior approval required)	D9230
Intravenous conscious sedation - first 30 minutes	D9241
Intravenous conscious sedation/ analgesia each additional 15 minutes	D9242
Non-Intravenous Conscious Sedation	D9248
OTHER DENTAL SERVICES	
Surgical Incision	
Incision and drainage of abscess - intraoral soft tissue (health check)	D7510
Incision and drainage of abscess - extraoral soft tissue (health check)	D7520
Periodontal Procedures	
Periodontal Scaling and Root Planning four or more contiguous teeth or bounded teeth spaces per quadrant	D4341
Gingivectomy or Gingivoplaty-four or more contiguous teeth or bounded teeth spaces per quadrant	D4210
Gingivectomy or gingivoplasty - one to three teeth per quadrant	D4211
Root Canals	
Anterior (excluding final restoration)	D3310
Bicuspid (excluding final restoration)	D3320
Root canal - molar (excluding final restoration)	D3330
Preventative Space Management Therapy	
Space maintainer - fixed – unilateral	D1510
Space maintainer – fixed – bilateral	D1515
Space maintainer - removable bilateral	D1525
Re-cementation of Space Maintainer	D1550
Prosthodontic Services, Removable Complete Dentures	
Complete denture maxillary	D5110
Complete denture mandibular	D5120
Partial Dentures	
Maxillary Partial-Resin Base (age 0-16 yr) (Including any Conventional Clasps, Rests and Teeth) (>age 16 yrs)	D5211
Mandibular Partial-Resin Base (age 0-16 yr) (Including Conventional Clasps, Rests and Teeth) (>ag 16 yrs)	D5212

Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth	D5213
Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)	D5214
Repairs to Dentures	
Repair broken complete denture base	D5510
Replace missing or broken teeth - complete denture (each tooth)	D5520
Repair resin denture base	D5610
Repair cast framework	D5620
Repair or replace broken clasp	D5630
Replace broken teeth - per tooth	D5640
Add tooth to existing partial denture	D5650
Add clasp to existing partial denture	D5660
Reline complete maxillary denture (chairside)	D5730
Reline complete mandibular denture (chairside)	D5731
Reline partial maxillary denture (chairside)	D5740
Reline partial mandibular denture (chairside)	D5741
Reline complete maxillary denture (laboratory)	D5750
Reline complete mandibular denture (laboratory)	D5751
Reline partial maxillary denture (laboratory)	D5760
Reline partial mandibular denture (laboratory)	D5761
Alveoplasty	
Alveoplasty in conjunction with extractions - four or more teeth or tooth spaces, per quad	D7310
Alveoplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quad	D7320
Apexification/Recalcification	
Apexification/recalcification - initial	D3351
Apexification/recalcification - interim	D3352
Apexification/recalcification - final	D3353
Other Repair Procedure	
Frenulectomy (frenectomy or frenotomy) - separate procedure	D7960

HIPAA BUSINESS ASSOCIATE AGREEMENT TO COMPLY WITH PRIVACY AND SECURITY RULES

THIS BUSINESS ASSOCIATE AGREEMENT (hereinafter "Agreement") is between **The State of Tennessee, Department of Finance and Administration** (hereinafter "Covered Entity") and **National Guardian Life Insurance Company** (hereinafter "Business Associate"). Covered Entity and Business Associate may be referred to herein individually as "Party" or collectively as "Parties."

BACKGROUND

Covered Entity acknowledges that it is subject to the Privacy and Security Rules (45 CFR Parts 160 and 164) promulgated by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191 in certain aspects of its operations.

Business Associate provides services to Covered Entity pursuant to one or more contractual relationships detailed below and hereinafter referred to as "Service Contracts"

- **FA-08-** 2392/-00

In the course of executing Service Contracts, Business Associate may come into contact with, use, or disclose Protected Health Information (defined in Section 1.8 below). Said Service Contracts are hereby incorporated by reference and shall be taken and considered as a part of this document the same as if fully set out herein.

In accordance with the federal privacy and security regulations set forth at 45 C.F.R. Part 160 and Part 164, Subparts A, C, and E, which require Covered Entity to have a written memorandum with each of its internal Business Associates, the Parties wish to establish satisfactory assurances that Business Associate will appropriately safeguard "Protected Health Information" and, therefore, make this Agreement.

DEFINITIONS

1.1 Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in 45 CFR §§ 160.103, 164.103, 164.304, 164.501 and 164.504.

1.2 "Designated Record Set" shall have the meaning set out in its definition at 45 C.F.R. § 164.501.

1.3 "Electronic Protected Health Care Information" shall have the meaning set out in its definition at 45 C.F.R. § 160.103.

1.4 "Health Care Operations" shall have the meaning set out in its definition at 45 C.F.R. § 164.501.

1.5 "Individual" shall have the same meaning as the term "individual" in 45 CFR § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).

1.6 "Privacy Official" shall have the meaning as set out in its definition at 45 C.F.R. § 164.530(a)(1).

1.7 "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, subparts A, and E.

1.8 "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR § 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

1.9 "Required by Law" shall have the meaning set forth in 45 CFR § 164.512.

1.10 "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR Parts 160 and 164, Subparts A and C.

2. OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE (Privacy Rule)

2.1 Business Associate agrees to fully comply with the requirements under the Privacy Rule applicable to "business associates," as that term is defined in the Privacy Rule and not use or further disclose Protected Health Information other than as permitted or required by this Agreement, the Service Contracts, or as Required By Law. In case of any conflict between this Agreement and the Service Contracts, this Agreement shall govern.

2.2 Business Associate agrees to use appropriate procedural, physical, and electronic safeguards to prevent use or disclosure of Protected Health Information other than as provided for by this Agreement. Said safeguards shall include, but are not limited to, requiring employees to agree to use or disclose Protected Health Information only as permitted or required by this Agreement and taking related disciplinary actions for inappropriate use or disclosure as necessary.

2.3 Business Associate shall require any agent, including a subcontractor, to whom it provides Protected Health Information received from, created or received by, Business Associate on behalf of Covered Entity or that carries out any duties for the Business Associate involving the use, custody, disclosure, creation of, or access to Protected Health Information, to agree, by written contract with Business Associate, to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.

2.4 Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement.

2.5 Business Associate agrees to require its employees, agents, and subcontractors to promptly report, to Business Associate, any use or disclosure of Protected Health Information in violation of this Agreement. Business Associate agrees to report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Agreement

2.6 If Business Associate receives Protected Health Information from Covered Entity in a Designated Record Set, then Business Associate agrees to provide access, at the request of Covered Entity, to Protected Health Information in a Designated Record Set, to Covered Entity or, as directed by covered Entity, to an Individual in order to meet the requirements under 45 CFR § 164.524, provided that Business Associate shall have at least seven (7) days business days from Covered Entity notice to provide access to, or deliver such information.

2.7 If Business Associate receives Protected Health Information from Covered Entity in a Designated Record Set, then Business Associate agrees to make any amendments to Protected Health Information in a Designated Record Set that the Covered Entity directs or agrees to pursuant to the 45 CFR § 164.526 at the request of Covered Entity or an Individual, and in the time and manner designated by Covered Entity, provided that Business Associate shall have at least thirty (30) days from Covered Entity notice to make an amendment.

2.8 Business Associate agrees to make its internal practices, books, and records including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, created by or received by Business Associate on behalf of, Covered Entity available to the Secretary of the United States Department of Health in Human Services or the Secretary's designee, in a time and manner designated by the Secretary, for purposes of determining Covered Entity's or Business Associate's compliance with the Privacy Rule.

2.9 Business Associate agrees to document disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosure of Protected Health Information in accordance with 45 CFR § 164.528.

2.10 Business Associate agrees to provide Covered Entity or an Individual, in time and manner designated by Covered Entity, information collected in accordance with this Agreement, to permit Covered Entity to respond to a request by an Individual for and accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528, provided that Business Associate shall have at least seven (7) days from Covered Entity notice to provide access to, or deliver such information which shall include, at minimum, (a) date of the disclosure; (b) name of the third party to whom the Protected Health Information was disclosed and, if known, the address of the third party; (c) brief description of the disclosed information; and (d) brief explanation of the purpose and basis for such disclosure.

2.11 Business Associate agrees it must limit any use, disclosure, or request for use or disclosure of Protected Health Information to the minimum amount necessary to accomplish the intended purpose of the use, disclosure, or request in accordance with the requirements of the Privacy Rule.

2.11.1 Business Associate represents to Covered Entity that all its uses and disclosures of, or requests for, Protected Health Information shall be the minimum necessary in accordance with the Privacy Rule requirements.

2.11.2 Covered Entity may, pursuant to the Privacy Rule, reasonably rely on any requested disclosure as the minimum necessary for the stated purpose when the information is requested by Business Associate.

2.11.3 Business Associate acknowledges that if Business Associate is also a covered entity, as defined by the Privacy Rule, Business Associate is required, independent of Business Associate's obligations under this Memorandum, to comply with the Privacy Rule's minimum necessary requirements when making any request for Protected Health Information from Covered Entity.

2.12 Business Associate agrees to adequately and properly maintain all Protected Health Information received from, or created or received on behalf of, Covered Entity

2.13 If Business Associate receives a request from an Individual for a copy of the individual's Protected Health Information, and the Protected Health Information is in the sole possession of the Business Associate, Business Associate will provide the requested copies to the individual and notify the Covered Entity of such action. If Business Associate receives a request for Protected Health Information in the possession of the Covered Entity, or receives a request to exercise other individual rights as set forth in the Privacy Rule, Business Associate shall notify Covered Entity of such request and forward the request to Covered Entity. Business Associate shall then assist Covered Entity in responding to the request.

2.14 Business Associate agrees to fully cooperate in good faith with and to assist Covered Entity in complying with the requirements of the Privacy Rule.

3 OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE (Security Rule)

3.1 Business Associate agrees to fully comply with the requirements under the Security Rule applicable to "business associates," as that term is defined in the Security Rule. In case of any conflict between this Agreement and Service Agreements, this Agreement shall govern.

3.2 Business Associate agrees to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the covered entity as required by the Security Rule.

3.3 Business Associate shall ensure that any agent, including a subcontractor, to whom it provides electronic protected health information received from or created for Covered Entity or that carries out any duties for the Business Associate involving the use, custody, disclosure, creation of, or access to Protected Health Information supplied by Covered Entity, to agree, by written contract (or the appropriate equivalent if the agent is a government entity) with Business Associate, to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.

3.4 Business Associate agrees to require its employees, agents, and subcontractors to report to Business Associate within five (5) business days, any Security Incident (as that term is defined in 45 CFR Section 164.304) of which it becomes aware. Business Associate agrees to promptly report any Security Incident of which it becomes aware to Covered Entity.

3.5 Business Associate agrees to make its internal practices, books, and records including policies and procedures relating to the security of electronic protected health information received from, created by or received by Business Associate on behalf of, Covered Entity available to the Secretary of the United States Department of Health in Human Services or the Secretary's designee, in a time and manner designated by the Secretary, for purposes of determining Covered Entity's or Business Associate's compliance with the Security Rule.

3.6 Business Associate agrees to fully cooperate in good faith with and to assist Covered Entity in complying with the requirements of the Security Rule.

4. PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE

4.1 Except as otherwise limited in this Agreement, Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in Service Contracts, provided that such use or disclosure would not violate the Privacy and Security Rule, if done by Covered Entity.

4.2 Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information as required for Business Associate's proper management and administration or to carry out the legal responsibilities of the Business Associate.

4.3 Except as otherwise limited in this Agreement, Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate, provided that disclosures are Required By Law, or provided that, if Business Associate discloses any Protected Health Information to a third party for such a purpose, Business Associate shall enter into a written agreement with such third party requiring the third party to: (a) maintain the confidentiality, integrity, and availability of Protected Health Information and not to use or further disclose such information except as Required By Law or for the purpose for which it was disclosed, and (b) notify Business Associate of any instances in which it becomes aware in which the confidentiality, integrity, and/or availability of the Protected Health Information is breached.

4.4 Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information to provide Data Aggregation services to Covered Entity as permitted by 42 CFR § 164.504(e)(2)(i)(B).

4.5 Business Associate may use Protected Health Information to report violations of law to appropriate Federal and State Authorities consistent with 45 CFR 164.502(j)(1)

5. OBLIGATIONS OF COVERED ENTITY

5.1 Covered Entity shall provide Business Associate with the notice of Privacy Practices that Covered Entity produces in accordance with 45 CFR § 164.520, as well as any changes to such notice. Covered Entity shall notify Business Associate of any limitations in its notice that affect Business Associate's use or disclosure of Protected Health Information.

5.2 Covered Entity shall provide Business Associate with any changes in, or revocation of, permission by an Individual to use or disclose Protected Health Information, if such changes affect Business Associate's permitted or required uses.

5.3 Covered Entity shall notify Business Associate of any restriction to the use or disclosure of Protected Health Information that Covered Entity has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Business Associate's use of Protected Health Information.

6. PERMISSIBLE REQUESTS BY COVERED ENTITY

6.1 Covered Entity shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy or Security Rule, if done by Covered Entity.

7. TERM AND TERMINATION

7.1 Term. This Agreement shall be effective as of the date on which it is signed by both parties and shall terminate when all of the Protected Health Information provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy Protected Health Information, Section 7.3. below shall apply.

7.2 Termination for Cause.

7.2.1. This Agreement authorizes and Business Associate acknowledges and agrees Covered Entity shall have the right to immediately terminate this Agreement and Service Contracts in the event Business Associate fails to comply with, or violates a material provision of, requirements of the Privacy and/or Security Rule or this Memorandum.

7.2.2. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall either:

7.2.2.1. Provide a reasonable opportunity for Business Associate to cure the breach or end the violation, or

7.2.2.2. If Business Associate has breached a material term of this Agreement and cure is not possible or if Business Associate does not cure a curable breach or end the violation within a reasonable time as specified by, and at the sole discretion of, Covered Entity, Covered Entity may immediately terminate this Agreement and the Service Agreement.

7.2.2.3. If neither cure nor termination is feasible, Covered Entity shall report the violation to the Secretary of the United States Department of Health in Human Services or the Secretary's designee.

7.3 Effect of Termination.

7.3.1. Except as provided in Section 7.3.2. below, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Entity, or created or received by Business Associate on behalf of, Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.

7.3.2. In the event that Business Associate determines that returning or destroying the Protected Health Information is not feasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction unfeasible. Upon mutual agreement of the Parties that return or destruction of Protected Health Information is unfeasible, Business Associate shall extend the protections of this Memorandum to such Protected Health Information and limit further

uses and disclosures of such Protected Health Information to those purposes that make the return or destruction unfeasible, for so long as Business Associate maintains such Protected Health Information.

8. MISCELLANEOUS

8.1 Regulatory Reference. A reference in this Agreement to a section in the Privacy and /or Security Rule means the section as in effect or as amended.

8.2 Amendment. The Parties agree to take such action as is necessary to amend this Memorandum from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy and Security Rules and the Health Insurance Portability and Accountability Act, Public Law 104-191. Business Associate and Covered Entity shall comply with any amendment to the Privacy and Security Rules, the Health Insurance Portability and Accountability Act, Public Law 104-191, and related regulations upon the effective date of such amendment, regardless of whether this Agreement has been formally amended.

8.3 Survival. The respective rights and obligations of Business Associate under Section 7.3. of this Memorandum shall survive the termination of this Agreement.

8.4 Interpretation. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Covered Entity and the Business Associate to comply with the Privacy and Security Rules.

8.5 Notices and Communications. All instructions, notices, consents, demands, or other communications required or contemplated by this Agreement shall be in writing and shall be delivered by hand, by facsimile transmission, by overnight courier service, or by first class mail, postage prepaid, addressed to the respective party at the appropriate facsimile number or address as set forth below, or to such other party, facsimile number, or address as may be hereafter specified by written notice.

COVERED ENTITY:
Name: M.D. Goetz, Jr.
Title: Commissioner of the Department of Finance and Administration, State of Tennessee
Address: 312 8th Avenue, North
Nashville, Tennessee 37243-0295
Phone: 615-253-8358
Fax: 615-253-8556
Email Address: dave.goetz@state.tn.us

BUSINESS ASSOCIATE:
Name: David Allen
Title: Assistant Vice President and Actuary
Address: National Guardian Life Insurance Company
Two E. Gilman St.
Madison, WI 53703
Phone: 608-443-5277
Fax: 608-257-1808
Email Address: djallen@nglic.com

All instructions, notices, consents, demands, or other communications shall be considered effectively given as of the date of hand delivery; as of the date specified for overnight courier service delivery; as of three (3) business days after the date of mailing; or on the day the facsimile transmission is received mechanically by the facsimile machine at the receiving location and receipt is verbally confirmed by the sender.

8.6 Strict Compliance. No failure by any Party to insist upon strict compliance with any term or provision of this Agreement, to exercise any option, to enforce any right, or to seek any remedy upon any default of any other Party shall affect, or constitute a waiver of, any Party's right to insist upon such strict compliance, exercise that option, enforce that right, or seek that remedy with respect to that default or any prior, contemporaneous, or subsequent default. No custom or practice of the Parties at variance with any provision of this Agreement shall affect, or constitute a waiver of, any Party's right to demand strict compliance with all provisions of this Agreement.

8.7 Severability. With respect to any provision of this Agreement finally determined by a court of competent jurisdiction to be unenforceable, such court shall have jurisdiction to reform such provision so that it is enforceable to the maximum extent permitted by applicable law, and the

Parties shall abide by such court's determination. In the event that any provision of this Agreement cannot be reformed, such provision shall be deemed to be severed from this Agreement, but every other provision of this Agreement shall remain in full force and effect.

8.8 Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of Tennessee except to the extent that Tennessee law has been pre-empted by HIPAA.

8.9 Compensation. There shall be **no** remuneration for performance under this Agreement except as specifically provided by, in, and through, existing administrative requirements of Tennessee State government and services contracts referenced herein.

IN WITNESS WHEREOF,

NATIONAL GUARDIAN LIFE INSURANCE COMPANY:

JOHN D. LARSON, CHAIRMAN, PRESIDENT & CEO 3-12-2008

NAME & TITLE **Date:**

DEPARTMENT OF FINANCE AND ADMINISTRATION:

M.D. Goetz, Jr. 3-18-08

NAME & TITLE **Date:**